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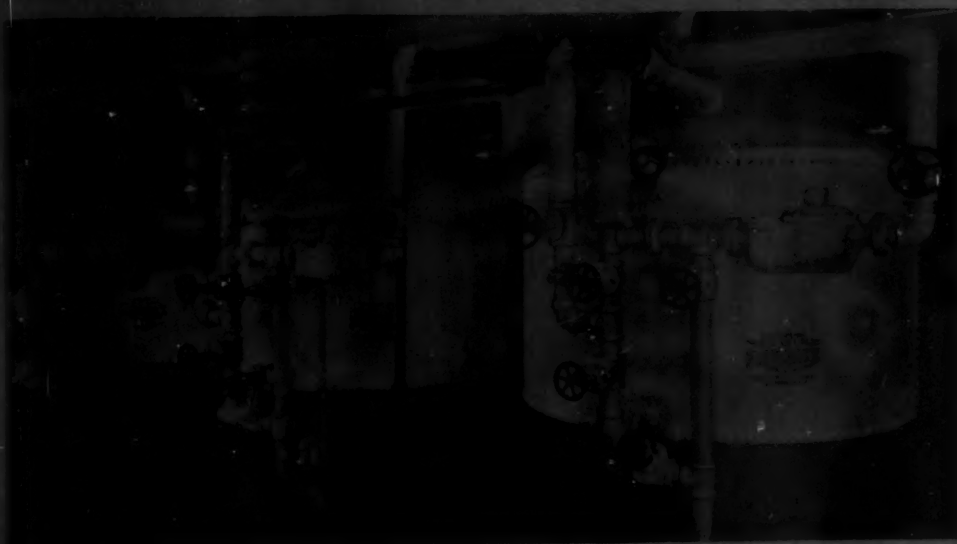
# *The* MODERN HOSPITAL

Vol. XXVI

May 1926

No. 5

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New Madison Hospital, Madison, S. D.  
Providence Hospital, Moose Jaw, Sask.  
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# THE MODERN HOSPITAL

*A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services*

Vol. XXVI

May 1926

No. 5

## DEVELOPING STANDARDS OF ACCOUNTING AND ADMINISTRATION

By Ellen C. Potter, M.D., Secretary, Department of Welfare of Pennsylvania,  
Harrisburg, Pa.

A HOSPITAL considered as a business has a service to sell. This service is the diagnosis and cure of disease and injury; and if we accept, as indeed we must, the modern concept of medical practice, the hospital also has health to sell both to the individual and the community through a well coordinated program of positive health education and clinical service.

These services are to be sold not only to the rich and the poor but to the great middle class which is, after all, the backbone of our democracy.

It has been frequently said that the average middle class man and his family cannot afford to be ill because they cannot obtain at a price that they can afford to pay, the medical, surgical and hospital care that they need, and their self-respect will not permit them to ask for charity.

The modern hospital, therefore, has before it the problem of providing its services in such fashion that an equally good brand shall be available at a cost within the reasonable financial grasp of the three great classes of people who at some time during their "earthly pilgrimage" must avail themselves of hospital facilities. This means that the cost must range from no charge at all to a maximum charge that shall completely cover the cost of rendering the service and shall provide for depreciation of the hospital plant.

If a hospital is to accomplish this without great stress, there must be at its inception careful consideration as to the need for the hospital at the point at which it is proposed to establish it; a careful calculation of the bed capacity in relation to the population it is proposed to serve and the

types of service needed. The building must be so planned as to minimize the cost of rendering service; the construction must be such as to minimize depreciation and consequent need for repairs; and in addition very careful calculation as to cubic space devoted to various activities, whether private rooms, wards or auxiliary services, must be made in order that charges may be based upon the known cost of rendering service.

In the majority of hospitals now in operation, many if not most of these factors have been entirely overlooked in the original planning of the undertaking. Many are remodeled private dwellings; others built for hospital purposes were planned on ample lines, as were the hotels of an earlier period, without much consideration of the value of or earning capacity of a cubic foot of space.

Added to the inadequacy of original planning for the majority of hospitals, it is a fact that until recently few institutions so conducted their business administration and accounting that they could tell what it really cost them to render a given service.

Charges made for service by most hospitals were based upon a "rule of thumb" that had no relation to costs, and in many instances they carried on the old tradition of "a dollar a day on the wards."

The Department of Welfare of the State of Pennsylvania entered upon its duties of supervising state aid to hospitals in 1921, at a time when the problems of hospital administration were exceedingly complex and when hospital finances were at a low ebb.



The system of state subsidy to private charity on a generous scale is peculiar to Pennsylvania and its historic background deserves some consideration. (New York City is the only governmental unit comparable to Pennsylvania in regard to appropriations for the care of the sick poor.)

Since colonial days, Pennsylvania has subsidized, to a greater or less degree, her private charities, especially her hospitals. The need that brought about the establishment of this policy is attributable to the fact that the state, organized as a free colony, had thrust upon it, through lack of restrictive emigration laws, an excessive number of dependents, as contrasted with its neighbors. These emigrants, constituting a large dependent class, were "dumped" upon the wharves of the chief city of the colony, Philadelphia.

Pennsylvania's poor laws, modeled on the lines of the Elizabethan system, placed the responsibility for the care of the poor and needy upon local poor law officials, but the concentration of need in the port of Philadelphia created a burden too heavy to be carried by the local community. It is stated that the system of relief for the poor actually broke down because of lack of sufficient income from taxation for that purpose, and that repeated assessments had to be made within a twelve-month to even approximate the local needs.

Moreover, the housing and feeding of these unfortunate passengers in the emigrant ships was such that a large proportion of those who lived to land on our shores were ill and in need of hospitalization.

The Pennsylvania Hospital, organized in 1750, had to carry the brunt of this service and the first appropriation toward the support of local hospital charity was made in 1751, when it was found that the local taxpayers and philanthropists were unable to cope with a situation that had acquired a significance of more than local importance. An appropriation of 2,000 pounds sterling was made in 1751 for the erection of a building, provided the community raised an equal amount. Previous to 1805 the sum appropriated to this institution amounted to approximately \$70,000.\*

\*The Pennsylvania Hospital has received no state aid for more than one hundred years.

From 1793 to 1875, a period of eighty-two years, there was appropriated to private hospitals \$645,166. These appropriations reached their peak in 1921 when \$6,457,100 was appropriated for a biennial period.

Such generosity on the part of the state has had its disadvantages as well as its advantages, but the method of appropriating and administering this great state charity until 1921 has had no redeeming feature but instead has worked distinct injury to the hospitals.

The state grants were made in individual appropriation bills, passed by a "vote of two-thirds of all the members elected to each house." They constituted Pennsylvania's "pork barrel" and all too often an assemblyman's strength was measured by the appropriations he secured for his local hospitals.

The mode of administration of these funds required that hospitals should show a deficiency in their cost of operation if they were to receive any money under their appropriation act. This inevitably placed a premium upon poor business methods and tempted those in charge of the hospital affairs to "juggle the books" in order to show a deficiency.

This injury to the hospitals is shown in the deplorable lack of endowments among those hospitals that are state-aided. Out of 148 such hospitals in 1924 only 69, or 46.3 per cent showed any earnings from endowments.

The tabulation below of the 69 hospitals that report endowments indicates the meagreness of their resources.

Amount of endowment	Number of Hospitals Reporting
Less than \$10,000 .....	16
\$10,000 but under \$50,000 .....	16
\$50,000 but under \$100,000 .....	10
\$100,000 but under \$500,000 .....	19
\$500,000 but under \$1,000,000 .....	3
\$1,000,000 and over .....	5
	69

The total amount of endowments was \$13,778, 049 or at the rate of \$1,559 per bed, which is ob-

Patients		Record No.	Admissions			Discharge			Patient Days			Settlement		Sponsor	Physician
Name	Address		Date	A.M.	P.M.	Date	A.M.	P.M.	Full Pay	Part Pay	Free	Am't Paid	Bal. Due		

Fig. 1.





eration of plant; (D) maintenance (repair) are apportioned on the basis of the relative floor area of rooms and wards assigned to each class of patients. If the ceilings are of unequal height, then the cubic space must be used instead.

5. The costs of (F) anesthesia; x-ray; special therapy; laboratory; motor service are apportioned on the basis of the number of occasions on which service is rendered to the various classes of patients.

6. The (G) social service and (H) out-patient apportionment is the actual cost of service rendered.

With this classification and distribution it is possible to approximate the costs of rendering various services and, therefore, to establish a basis for charges.

Cash receipts are classified under the following headings:

1. Income from Patients:

Board and general service	Laboratory
Operating room	Nurses board
Delivery room	Drugs
Nursery	Medical and surgical supplies
Anesthetics	
X-ray	Ambulance or auto
Special therapy	Other receipts

The receipts are further classified as income from (a) Full pay and (b) part-pay patients.

2. Miscellaneous Receipts:

Sale of materials; Dispensary and other out-patient service.

Short term loans; Telephone, telegraph and sundries.

3. Local Aid:

Donations and proceeds from fairs, etc. Corporation and other subsidies.

City, county and poor district appropriations.

4. Fixed Income:

Endowment earnings and rents;

Income from funds.

5. State appropriations.

This classification makes it possible for the state to ascertain the amount of money received from local sources by the hospital and thus to measure the sense of responsibility that the local community, both official and unofficial, really assumes in contrast to that assumed by the state.

In order to make the accounting system effective, a central storeroom with a properly operated system of requisitions by departments was insisted upon in all institutions except those of such small size that their daily purchases went into daily use and were thus accounted for.

To the well trained hospital executive it will

perhaps seem inconceivable that these simple business methods were lacking in a large number of our state-aided institutions, and that to many the installation of the cost accounting system seemed the imposition of an unnecessary hardship and expense. It is today the almost unanimous opinion of our hospital executives that the system of cost accounting now in force is essential to the intelligent operation of a hospital and that it enables the executive to detect leaks and extravagance before serious damage has been done to the institutional finances.

### Ability to Show Deficiency

In the early months during which the accounting system was being established the hospitals were receiving their compensation from the state on the old basis of "ability to show a deficiency," without reference to the days of service rendered the sick poor. A study of the figures submitted by the hospitals themselves at an earlier date (Bureau of Municipal Research, Philadelphia, 1920) showed that under that method some hospitals received as little as three cents per free day while others received \$4.32 per free day.

It was evident, therefore, that a standard system of accounting for patient days of treatment must be established and that only those patients accepted as state wards should be considered in calculating the obligation of the state to the individual hospital.

A patient register was therefore set up for all hospitals under the headings shown in Fig. 1.

A uniform method of calculating days of care was established and the card form in use at the Conemaugh Valley Hospital, Johnstown, was distributed by our Prison Labor Print Shop to all state-aided hospitals to facilitate ease in calculation.

It was necessary to establish a means of identifying the patient accepted as a state charge. In cooperation with the executive committee of the state hospital association a form of credit card was devised similar to that accepted as part of a social service investigation. Upon this card the patient based his application for care in the hospital at the expense of the state and affixed his signature thereto. (Fig. 2.)

It was at this point that we reached the conclusion that "faith" had no place in a scheme of hospital administration, but rather that facts as to the ability of a patient to pay, and how much he should be required to pay after a careful social investigation, was the only fair method both to the patient, philanthropic public, hospital trustees and the state.

The old method of state appropriating to hos-



pitals made it possible for the executive to charge to the state all the days not paid for by private patients, or uncollected from compensation, casualty and insurance companies, by the indirect method of "showing a deficit" which, as a matter of fact, could have been avoided by businesslike collections and an economical system of purchase.

The department proposed to encourage good business methods by making payment to the hospitals for service rendered at a per diem rate not to exceed the cost of rendering the service on the wards of the hospital. Such a plan made it unnecessary for the hospital to show a deficit in order to collect from the state the amount appropriated. Payment was to be based upon work done for worthy applicants and not upon "pull." The hospitals were, therefore, required to submit the names of those patients for whom they claimed payment from the state on a special form, later to be checked by our representative against the patient register and credit card, Form 65. (Fig. 2.)

It was evident from our field work, covering a period of twelve months, that there was a serious lack of understanding, on the part of hospital executives in small cities and rural districts, of the social service implications growing out of hospital credit work. It became our purpose to familiarize them with the social resources of their communities and of the state, and to assist them in the solution of their practical problems.

We therefore appointed as our field representatives, whose duty it was to make the quarterly periodic check of patients eligible for care at the state's expense, trained hospital social workers who were competent to interpret the significance of hospital credit in the light of sound social practice. As a result we hope ultimately to see the establishment of a real hospital social service in all state-aided hospitals. In addition to three (women) field representatives of this type, a fourth (man) familiar with hospital accounting covers the field and an interchange of service is possible where needed.

#### Responsibility for Financial Audit

While the department of welfare is responsible for the audit of free "patient days" for which the state compensates the hospital, the financial audit is the responsibility of the auditor general's department and his quarterly audit combined with the accounting for patients establishes under our present system the actual ward cost and the amount that the hospital is to receive. The total amount to be received by any hospital is limited by the appropriation awarded it by the assembly and approved by the governor.

In order to establish the system of state subsidy

on a sound business basis, as contrasted with that of political preferment, the department sought to secure in the legislative session of 1923 the abandonment of the time-honored practice of individual appropriations to each hospital and to substitute for that an appropriation in a lump sum to the department of welfare for the purpose of purchasing from the hospitals care for the indigent sick at a per diem rate.

#### Appropriation at Per Diem Cost

This we were unable to accomplish, but we did secure at our urgent request a provision in each individual bill that the hospital should receive its appropriation at a per diem rate not to exceed \$3 for the care of the sick poor, and that in no event should the payment per diem exceed the actual cost of rendering the service on the ward. In addition the department was authorized to formulate the rules and regulations under which patients would be accepted and payments made.

These rules in brief define the types of patients who will be accepted as state wards and those who will not, and include practical suggestions as to details of the work to be done.

One paragraph is of particular significance in relation to the whole matter and was made necessary because of the tendency on the part of some hospital executives to be excessively severe in the matter of collections:

"Good judgment should be exercised at all times in passing on the ability of a patient or his relatives to pay. The credit officer should be quite as reasonable and sympathetic with the self-respecting man of very limited means as he is severe with the one who willfully attempts to avoid settlement. Serious consideration should be given to the laboring man with a family and modest home on whom a hospital bill would fall as a heavy burden, but whose self-respect forces him to cover up his real financial condition. State aid is given for the express purpose of helping in such emergencies."

The rules adopted indicate that the state will accept as a proper charge upon it for hospital care:

Class 1. A patient who is cared for on the wards of the hospital, regarding whose ability to pay suitable inquiry has been made, and who in the judgment of the credit officer would suffer an unjust hardship if required to pay the hospital charges in full or in part. This credit inquiry and the conclusion must be a matter of record on the Form No. 65.

Class 2. Employees of the hospital, exclusive of interns, pupil nurses and graduate nurses, for whom a credit card is made out in full and on

the basis of which a decision as to eligibility for free care is made.

Class 3. All babies born in the hospital to mothers who have been classified by the credit department as a proper charge upon the state, and all new-born babies brought into the hospital with the newly delivered mother who is classed as above.

Class 4. All compensation cases that after the first thirty days are found to need further care and that are found after the usual credit inquiry, as provided for in Form No. 65, not able to pay the hospital ward rates in full or in part without undue hardship.

Class 5. All compensation cases who before the tenth day have been removed from the hospital either by death or recovery and who have not been paid for in accordance with the provisions of the workmen's compensation act, provided that a suitable inquiry has been made as in Class 4.

#### Cases Not Accepted by the State

The state will not accept as a proper charge upon it for hospital care a patient:

1. Who occupies a private room, except that a patient otherwise entitled to free care may in an emergency be received into a private room until a ward bed is available; and that a patient *in extremis* may be transferred from a ward to a private room.

2. Who occupies a semi-private room.

3. Whose treatment is paid for by his employer in compliance with the provisions of the workmen's compensation act.

4. Who pays or whose sponsor or responsible relative pays a fee to the doctor associated with the patient. The patient's first obligation is to the hospital and one of the chief functions of the credit office is to see that the hospital's interests are protected.

5. Who is an intern, pupil nurse, or graduate nurse in the employ of the hospital.

6. Who is a non-resident of the State of Pennsylvania.

7. For whom a credit inquiry has not been made a matter of record on Form No. 65. (The inquiry for a baby shall be sufficient which states merely the classification of the mother).

8. Patients with chronic illnesses who have been in the hospital over ninety days, except in special hospitals, such as those for the treatment of tuberculosis, epilepsy, cancer, orthopedic defects, and those, who after consideration, are accepted by the field representative for special reasons for a longer period of time.

The question may be raised: "Is it not possible that hospitals may make false returns on patients

ineligible to receive state care and so cheat the state?" There is, of course, that possibility, but in actual practice such action is remote if trained field workers are employed. One conspicuous example of sharp practice that failed in the early days of the new system may have provided the needed lesson. Of 910 days reported as free by one hospital, an examination by our representative showed:

271 full pay days

17 casualty insurance cases

4 compensation cases

32 police cases

48 hospital employees

5 non-resident of Pennsylvania

1 private room case

5 not properly investigated

527 approved for payment.

Other instances have demonstrated that it is difficult to "beat the game;" it is gratifying to note, however, that there is little disposition on the part of hospital executives to try to do so.

The establishment of these definite standards throwing back upon the hospital the responsibility of collecting its own bills; together with the fact that state appropriations were reduced under the budget established by the Pinchot Administrative Code in 1923, as contrasted with 1921, brought the hospitals face to face with business reality and also rekindled a sense of local responsibility for hospital welfare in line with Pennsylvania's poor law tradition.

The credit investigation did not, as was expected by some pessimists, reduce the number of persons applying to the hospitals for care, and actually 16,683 more individuals were accepted for treatment with a decrease of 1 per cent in the total number of days of service given as between the years 1921 and 1924.

Hospitals were encouraged to establish a ward rate more nearly approximating their actual ward cost of rendering the service, as evidence of good business practice. The "ward rate charged" was adopted by us as the factor by which to determine the number of hospital days of care paid for by "part pay patients" and it was pointed out that the establishment of a higher "per diem rate charged" would, when divided into these partial payments, result in a smaller number of days paid for by the patients and a larger number, therefore, remaining to be paid for by the state.

If, under succeeding administrations, the system now in force is continued, the state-aided hospitals of Pennsylvania will, without doubt, find themselves on a sound financial basis, rendering a vital medical and social service to their respective communities.





## USING DISCRETION WHILE BESTOWING RELIEF

By William Everett Musgrave, M.D.,  
San Francisco, Calif.

**H**OSPITALS and other worth while medical agencies dependent upon private philanthropy for support in their service to the poor, have difficulty in securing necessary funds because of the abuse of such services by those able to finance themselves or otherwise deserving of private generosity. Doctors everywhere are active in their condemnation of institutions that ask and receive assistance in the name of charity for those often better able to pay their debts than are the doctors themselves. Therefore, any feasible plan calculated to introduce more justice into charity without destroying the spirit that is its very life deserves emulation.

Seven years ago the Children's Hospital of San Francisco initiated a plan that proved so successful in its appeal to physicians and to fair-minded people in general that, with various modifications, it is now in force in many of the better institutions serving the health of the worthy poor.

This plan is very simple. It has as its basis a social diagnosis arrived at, as are other diagnoses, by an intelligent consideration of all available evidence, the evidence being secured by sympathetic private conferences with trained social diagnosticians and fortified by evidence obtained through other channels not pertinent to this discourse. When the evidence is sufficient—service having in

the meantime been given—the diagnosis is made and fully explained, confidentially, to the patient. If a diagnosis of solvency is made, the patient is refused further service and instructed to see his private physician.

If a diagnosis of insolvency is made, its degree is fixed by agreement between the social diagnostician and the patient, both of whom sign to that effect on the specially designed social service record that is attached to and forms part of the patient's medical record, whether he receives service in clinic or hospital.

An important, far-reaching, many-faced feature of this service is the highly successful method of inviting the cooperation of all former doctors of the patient. Each doctor who has attended the patient is sent the following form letter with a return stamped, addressed envelope:

"My Dear Doctor: . . . . . living at . . . . . has applied to us for advice and treatment for . . . . . as a 'service' patient. Our investigation indicates that she is . . . . . able to pay a private physician and therefore properly may . . . . be granted the special rates and privileges requested.

"She states that you have attended her as a private physician and before making final decision as to her status here, we should appreciate an opinion from you as to whether she should be



referred to her private physician, charged a nominal hospital fee or given absolutely free care. Your answer will be considered confidential and is requested in order that we may carry out more accurately our policy of not competing with private physicians in the legitimate practice of their profession.

"A stamped addressed envelope is enclosed and a pencil note on the back of this sheet will be a convenient method of reply.

Sincerely yours,  
Children's Hospital,  
By .....

Many thousands of these letters form part of patients' records in the hospital and clinic. The 5,000 records examined for the purpose of this discourse are interesting reading and warrant certain deductions.

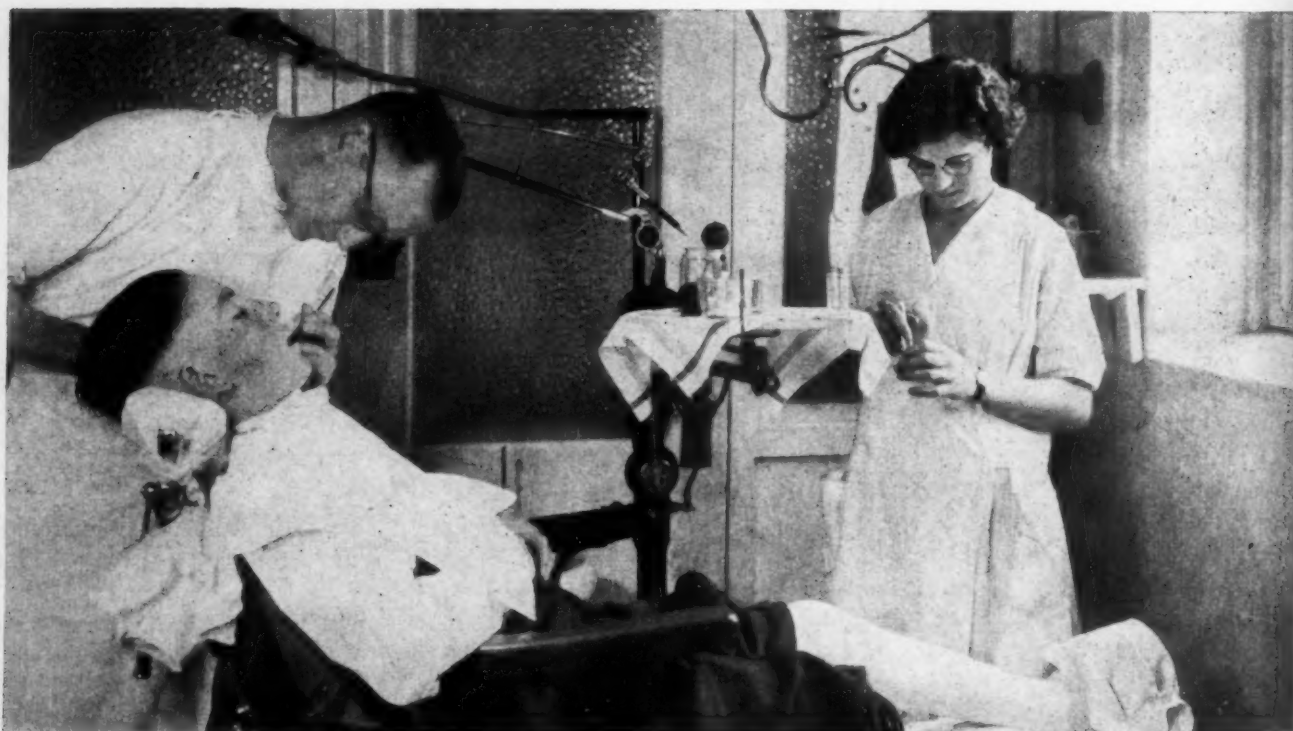
Of the 5,000 unselected letters sent, 2,260 were not returned. Legitimate reasons probably explained a thousand of these, and the reasons of the other thousand plus are just as well not discussed. Twenty-seven hundred forty doctors answered the letter and 1,838 of them endorsed the findings of the social diagnostician and commended the service, particularly the courtesy extended to the doctor. Three hundred ninety-six

few patients who gave wrong names, this finding turns an interesting sidelight on the record systems of some of our doctors. Hundreds of the doctors added notes of commendation of the plan in their replies; less than half a dozen criticized, and 278 wrote special letters of praise for the courtesy of the letter, and commended the extension of the idea.

There are many significant and human interest stories in the various letters and they tell so effectively of the far-reaching usefulness of the method that the following extracts from a few of them may help to extend the plan:

"I do not know the financial status of this family at the present time, but do not feel that they are people who would seek clinic treatment if they could afford a private physician. The last time I attended the patient it was a miscarriage. She was in a very bad condition and I had her moved to the free San Francisco County Hospital. Do all you can for her and if I can help let me know. Thank you for this extraordinary courtesy. It will make friends for you and redound to the good of the deserving poor."

"I thank you for writing me and I appreciate the attitude you are taking with regard to patients who apply for free service or at least for a reduced service fee. This lady I know well and her



Dental work being done in the out-patient department during hospital convalescence.

disagreed with the social diagnosis, and in each of these instances the patient was refused further service, and advised to return to his private doctor, who was so notified. There was a group of 228 patients of whom the doctors they claimed to have seen had no record or recollection. Aside from the

circumstances are very poor financially. I know of no financial backing except her relatives and they are not paying her bills. I consider her worthy of your free service department. I thank you particularly for this unusual spirit of cooperation with private doctors."

"Consideration of the wishes of Mrs. — is

perfectly satisfactory to me and I appreciate the policy of your institution and thank you for your notification. I operated on her husband for an inguinal hernia about six months ago. He has paid only fifty dollars, so I presume their financial condition is not good. Again thanking you and assuring you of my hearty cooperation in your unique and useful method of service."

Here is an instance where two doctors and two

owner of a successful blacksmith shop here, and I know of no reason why they should not pay full rates for any medical service. If more health shoppers who go from their family doctor to the city could fall into your hands, country people and country doctors would suffer less."

"I know of no reason why the person about whom inquiry is made should not pay for the service of a physician. They live in splendid quar-



Cast being changed in the out-patient department plaster room.

clinics were concerned in the case of one patient.

"I should not like to see these people become clinic patients. They have always seemed to me able to meet their bills."

To this letter the social service diagnostician replied:

"We have investigated Mrs. T—. She insists that her husband's employment is very unsteady and that she is unable to pay even a nominal clinic fee. However, she will not be accepted here for further service."

The other doctor concerned wrote:

"I have attended Mrs. T— as a private patient, without charge. I do believe she is entitled to the clinic care which she has been receiving for some time at another clinic. I believe the expedient thing for you to do would be to refer her to the other clinic where she is already registered. I feel she is inclined to be somewhat of a clinic 'tramp' which is not good for her."

"The lady in question has not yet found a physician who can retain her confidence, so if she has applied to your hospital for treatment, please do your best for her, but charge her a minimum fee for doctor and hospital care because she can well afford to pay for it. She is a typical bargain hunter in health."

An out-of-town doctor writes: "Thank you for your courtesy to C—. His father is sole

ters and the husband is employed at good wages. I recently attended her during a very critical illness and have not been paid—not because she cannot pay but because she does not desire to."

After a talk with the social service diagnostician, this patient went back to her doctor, paid her reasonable bill and engaged him to continue to care for her.

"This child is certainly deserving of charity. She has a stepfather and there are several other children in the family. She cannot be properly taken care of at home and they are too proud to go to the county hospital. They are worthy and I sincerely hope you can make satisfactory arrangements to care for her. If I can help by service or money in the fine thing you are doing, let me know."

"It is my opinion and that of other doctors with whom she shops that Mrs. — is able to pay but has no wish to do so."

"The husband is working and is able to pay a moderate sum for any attention to the boy. Both Mr. and Mrs. E— exact from their physician more than most people and are most unappreciative of anything done for them. Dr. M— was down to see the boy recently, by appointment, on the date of your letter and they were not at home. Evidently they have taken the boy to you without even so much as telling Dr. M—. If more clinics and health centers would use your



intelligent methods there would be greater cooperation from doctors and there would be far less abuse of charity."

"I wish to advise I have not seen or heard of the T—— family for five years. At that time I rendered services to the daughter, and my records show that the bill was promptly paid. So far as I can recall now, the family was in ordinary circumstances. I know nothing of their present condition. What a splendid thing you are doing."

"Miss A. C. is a most worthy person to be given care. I have known her many years and have attended her many times, always without charge as she was the sole support of an invalid mother. I most heartily recommend her for any consideration you may offer and compliment you upon your fine spirit of cooperation."

### CAN HOTEL-HOSPITAL SERVICE COMPETE WITH GENERAL HOSPITALS?

Recently, attention has been drawn to the establishment of hospital facilities or a hospital floor in the large metropolitan hotels.

In discussing this subject, Frank E. Chapman, director, Mount Sinai Hospital, Cleveland, says: "There is no particular reason and little real need for hotels to furnish hospital service or provide facilities by designating a certain floor for this service. Some hotels now have emergency medical service, but it is altogether improbable that they would be able to supply hospital service comparable to that furnished by a good hospital at anything like the low cost per patient day. In addition thereto, the public would react very unfavorably to an idea of housing patients in a hotel, even though the patients were isolated on a certain floor."

"It must be borne in mind," says Mr. Chapman, "that the hotel-hospital floor, of necessity, would be compelled to include as a part of its per capita cost the charges that are incident to the financing of a hotel and are not paralleled in the per capita cost of the regular hospital."

### THE FUNCTIONS OF A STATE HOSPITAL ASSOCIATION

At the first annual meeting of the Hospital Association of the State of New York, John M. Smith, executive secretary of the Hospital Association of Pennsylvania, gave the following definition of a state hospital association:

"A state hospital association is an organization of hospitals in a state working under leadership, with well defined duties and functions, acting in an orderly and cooperative way for the better care of the sick and injured."

"There are three classes of hospital associations, city or local associations, state or provincial associations, and national or international associations. Each one of these has a definite place and they should be affiliated with each other. The city association should have a cooperative arrangement with the state association and the state association should be a sectional member of the international association. It is important that all three types of associations get together and work out a plan of coordination that will make them more useful and that will be fair and just to all three classes."

"The functions of a state hospital association are somewhat as follows:

"1. To get together annually or oftener for the purpose of reading papers, carrying on constructive arguments and frankly and honestly discussing the various phases and details of hospital work and its relation to the community."

"2. The development of a spirit of cooperation and intercommunication among the hospitals of the state."

"3. The establishing and maintaining of minimum standards of service in the various departments of the hospital and the generous distribution of copies of such standards to the hospitals throughout the state."

"4. A hospital association should stimulate and guide hospital development throughout the state."

"5. To develop in the hospitals a sense of responsibility to the community in hospital matters and in health education."

"6. The state hospital association is, so far, the only practical means of communication between the hospitals and the state government. Laws necessary or helpful to the public health or to the improvement of working conditions for the hospitals, or amendments to existing laws can be drafted by a properly organized association and their introduction into the legislative body can be secured by an active legislative committee."

"7. To contribute to the hospital field at large by publishing and distributing the minutes of the meetings and preparing material for publications."

### COOPERATION PROMOTED THROUGH COMMUNITY CHEST

That hospitals should participate in a community fund is the recommendation of Clarence King, secretary, Bridgeport Financial Federation, Bridgeport, Conn.

"When two or more hospitals jointly participate in a community chest," he says, "it gives them a common economic interest that should stimulate team work, and be the means of meeting their deficit."

"The community chest campaign gives an opportunity to educate the rank and file of people of the community to the fact that the rate paid in the wards does not cover the full cost of service and that the community chest makes up this deficit. In order that the community chest may function successfully all hospitals that are members of this organization should adopt similar standards of policy."

The joint interest in the community chest tends to insure closer cooperation between the family agency, the visiting nurse association and the hospitals.

Æsculapius was fabled to have been the son of Apollo. In Homer's time there was no temple service in his honor. Later, however, the holy places became the seat of the rites of "incubation." Remedies that experience had proved valuable were written on tablets or engraved upon pillars in the temples and served to lay the foundation of written systems. In connection with this cult were the Asclepiads, who were lay doctors, distinct from the priests, in places where there were no "Asclepia" or shrines of the healing deity.—Burdett.

### ERRATUM

In publishing the floor plans of the surgical pavilion of St. Mary's Hospital, Rochester, Minn., on pages 202-204 of our March issue credit for designing these plans was mistakenly given to Messrs. Ellerbe and Company, St. Paul, Minn., who designed the other units of St. Mary's Hospital. The surgical pavilion was designed by Clarence H. Johnson, architect, St. Paul, Minn.



## HOW MUCH SHOULD INDUSTRY PAY?

### What 26 Hospitals Are Receiving

**D**ISCUSSION has recently been raised in various parts of the country, particularly in industrial centers, regarding the hospitalization of industrial cases.

In many places the state industrial compensation laws govern the rates that are to be paid per day for hospital care up to certain amounts, while in others no such laws are in effect. In any event there is a wide variance in charges made by hospitals in the different cities, although many of them are conducted under the same auspices and in sections where living conditions are similar.

In an effort to learn the attitude of hospitals that had taken care of many industrial cases, THE MODERN HOSPITAL a short time ago sent out an inquiry to thirty-five institutions in different areas, of different types and known to have treated many industrial cases in the past. The letter of inquiry read as follows:

"Will you jot down at the end of this letter (and return it to me) the amount that you usually charge various industries of your community or the liability insurance companies for hospitalized cases. I shall appreciate it also if you will tell me whether this charge is below cost, or cost, or at a slight profit for the class of service rendered."

#### What Insurance Companies Pay

So that there may be a better understanding of the entire proposition and so that hospital executives may profit from the statements of other superintendents the answers are herewith set down without the names of the hospitals in question:

"Most insurance companies allow us only \$3 a day for the care of patients which is below cost and is the rate in the wards. Semi-private rooms rate at \$4.50 which takes care of the cost. Most of our cases of this kind are at \$3 per day."

"We are granted the actual per capita cost per diem of the previous year by the Industrial Commission of Ohio for all industrial cases hospitalized by industries who insure through the commission. Accordingly, for the year 1926 the flat rate will be established to cover all cases admitted during this year and will be based upon the cost for the year 1925. This will be in the neighborhood of \$5.50 per day, the exact figure having not yet been established.

"Practically all Ohio industries insure through the State Industrial Commission, this being obligatory upon any person employing three or more

people. There are, however, a few industries who, under a special ruling, either carry their own insurance or insure through a private company. The State Industrial Commission requests that these people also be billed according to the established rate. There are, however, one or two companies in the city who are large users of private rooms and we could not afford to grant them the number of rooms they desire at the average cost per day, so that we bill these companies at the established hospital rates, both ward and private room rate being somewhat below cost to us. I feel that the basis upon which the Industrial Commission rate is fixed is very fair and does represent as nearly the actual cost as could be arrived at.

"There is, however, one difficulty that arises in the case of a hospital having a large maternity service. The infant patient days, for which no payment or only a small one is received, are used in establishing the per diem per capita rate, which materially reduces the Industrial Commission rate and makes it below cost for the type of service given to the usual industrial cases that are received here.

"With this one exception the Ohio arrangement seems to be fair to both the Industrial Commission and to the hospital. Our hospital rates are \$3.50 for ward bed, \$5.50, \$6.50 and \$7.50 for private rooms."

"We charge \$21 a week for room, \$15 for the use of the operating room and \$3 for laboratory work. Our weekly cost is \$29.20, so we are selling our services to industry for \$8.20 below cost."

"At our hospital the charge for such cases is \$3 per day which is below cost."

"The rate per week, limited by law, is \$21 for industrial cases. Our weekly per capita cost for 1925 was \$39.27."

"Our charge for industrial cases is \$2.50 per day for ward service which is below cost, and \$4.50 a day for semi-private rooms which is about cost."

"Our ward rates are \$2 per day, plus medicine, dressings, operating room and laboratory fees. Our rate for 1925 averaged \$3.88 per patient per day."

"Our charges for industrial cases vary from year to year. A contract charge is made according to our per capita cost at the end of the year. In 1924 our rate was \$5.15 per day; in 1925, \$4.86 per day and in 1926 our rate will again be \$5.15 per day. This is the actual cost of caring for a patient per day in the ward."

"We have been charging regular ward rates for compensation cases—\$2.50 per day which is below

cost. We are contemplating a change in rates for these cases."

"We make no contracts with companies. They pay the usual hospital prices. These cases are generally assigned to wards and the charge per bed is far below cost."

"Industrial cases, all classes, are charged ward rates of \$2.50 a day. Charges also are made for x-ray pictures, casts, baking or massage treatments and for dispensary treatments if these are necessary after discharge. These charges do not cover the cost by any means. Many insurance companies allow only the amount fixed by law, \$50, irrespective of the length of time the case may be in the hospital. Our cost of maintenance per person last year was \$3.74, which we consider low compared to the cost in some other institutions."

"We charge industries or insurance companies at the same rate as we do patients. Industrial cases cared for in wards, are charged the ward rate, those in semi-private rooms, the semi-private rate, those in private rooms according to the room occupied. Work done in the ward and semi-private rooms is below cost. In the case of private rooms there is usually a small profit."

"Our charges for compensation insurance cases are as follows: \$3 per day for general care whether hospitalized in private rooms or wards. X-ray examinations for liability insurance companies who routinely refer all their work to our laboratories, we make at 20 per cent less than list price. This reduction is not made in the case of companies from whom we get only an occasional examination."

"For hospitalized cases the usual extra charges for dressings and special medicine, as well as charges for operating room and physiotherapy treatments, are in addition to the \$3 per day charge. Our average per diem cost for the last fiscal year was \$3.75 per day. We estimate that at the rates charged liability companies we break just a little better than even."

"Formerly some of the adjusters attempted to insist upon the lowest price of ward accommodations for their patients. At this hospital ward rates are only \$2 per day. We felt that at this rate we should be doing work for the liability companies at considerably below cost and we have succeeded in persuading all of them to pay us \$3 per day for general care, and to pay for extras as indicated above."

"Rate for insurance cases is \$18 per week when patients are cared for in public wards where the usual charge is \$14. Our cost per patient per day for the entire hospital is \$3.90 per day. All extras, such as x-ray cost, laboratory examinations and special drugs, are charged to insurance companies at full rates."

"The rate for industrial insurance cases is \$4 per day; this is supposed to cover the cost but it does not quite do so."

"Our charge to the various industrial companies of our community is at a per capita cost, which is \$6 per diem if the industry is in the Ohio Industrial Commission. If not then the regular charges are made with a small discount of perhaps 5 per cent or so."

"Our charge is \$22.75 per week, which is considerably below cost but we receive from various factories a good-sized annual donation based on number of employees, so that we are actually paid more than cost."

"The charge we make for the care of workmen's compensation cases is \$25 a week, plus charges for apparatus and x-ray pictures. This does not quite cover our per capita cost but we make the same charge for x-ray plates in these cases as we do for private patients, and we have found by long years of observation that this brings the compensation to the hospital for these cases up to the actual cost of maintenance."

"When I came to this hospital the charge being made for these cases was \$2 per day, the same charge that was being made to ordinary ward cases, with the consequent loss of about \$1.50 per day for each one of these cases cared for."

"All the large insurance companies in this city are represented on our staff in some way or another and when we brought the matter to their attention they were very cooperative and did not feel that we should pauperize huge wealthy corporations. However, all of the companies who carried insurance in the state compensation commission were not so kindly disposed and in 1921 we succeeded in getting an amendment to the workmen's compensation laws which reads in part as follows: ' . . . but the liability of the employer for hospital service shall be the amount it actually costs the hospital to render the service.'"

"I think the universal charge in this state for compensation is now about \$25. Some hospitals charge more because their per capita cost is higher."

"At this hospital we have contracts with a number of concerns by which we charge them the flat rate of \$28 a week, which includes everything except massage and special nursing. Other industries with whom we have no contracts are charged at the rate of \$21 a week for general care plus operating room fee, x-ray fee and other extras."

"This just about evens up on the whole, as \$28 is hardly enough for short time cases but is ample for long time cases. We do not expect to make a profit. In our state our accident board fixes the charges that will be allowed for all ordinary compensation cases. Any addition to the amounts as fixed by them must be carefully arranged with the doctor in charge of the case and the firm carrying the liability."

"The charge made for compensation cases is the same as our regular ward rate, namely \$2.75 per day, which is considerably below the cost of maintaining a patient, this figure last year being \$4.49 per day."



"I believe that hospitals should be reimbursed for the care of this type of patient up to the full cost of maintenance. However, the compensation laws of Pennsylvania provide that the charge for the care of compensation cases shall be no higher than the rate regularly charged for patients receiving a similar class of service. I believe our ward rate is somewhat lower than it should be considering the present cost of maintenance. We are contemplating a change in this rate, establishing a rate that will more nearly meet the cost of maintenance."

"Insurance companies will pay only \$3 per day. This is our ten-bed ward price, but it is slightly below cost. The cost per capita is \$4.02."

"The charge made to liability and insurance companies for hospitalized cases is \$3 a day, with a charge of \$5 for the use of the operating room. This charge is below cost, but is all that the industrial accident board in this state will authorize."

"I feel that industrial accident cases should pay at least the actual cost to the hospitals, but we seem powerless to remedy this condition."

"There is a very strict compensation law in force in the state of Pennsylvania and no matter how long a compensation case is in our hospital the amount paid for treatment and services must not exceed \$100."

"This amount was set down by the state workmen's compensation division which is a part of the state administration, and all insurance companies in Pennsylvania who carry compensation insurance for individual concerns naturally have adopted the same ruling."

"We have at present no ward set aside especially for compensation cases. We are charging for those cases the same rate as is charged to our general ward cases, that is, \$3 a day. This amount is below cost but we have not been able to increase this charge in compensation cases because nearly all the hospitals are charging the same rate."

"Of course, we are allowed, when a case is in the house less than thirty days, to make separate charges for x-ray examinations, laboratory tests and plaster casts. Our bill nevertheless must not exceed \$100 in any case."

"Our rate to industrial concerns is our cost per capita which for the year 1925 was \$5.92, this applies to all hospitalized industrial cases and self-insuring company cases."

"Only one industry pays us directly for compensation cases. They give us \$4.25 and all extras at ward rates, which are about half our full rates. We charge insurance companies \$4 per day. Our cost per patient per day is \$5."

"We have great trouble in collecting our full bills from the insurance companies, some claiming that under the Pennsylvania compensation law they are only to pay us \$3 a day and others that although they will pay us \$4 they will never pay us more than a total of \$100 for a compensation case."

"There should be a concerted effort in the whole field to establish our relations with insurance companies on a reasonable basis, for the insurance companies are unreasonable in refusing to pay our bills."

"We receive from industrial patients a per diem rate of \$3.50 and in addition such extras as charges for operating room, x-ray and special supplies."

"Our per capita cost last year for this type of case was approximately \$4.60. Our general per capita cost in the hospital as a whole was \$5.06. You will see, therefore, that we are not receiving cost for this type of work."

"We have from time to time considered increasing our rates for compensation patients to the approximate cost. This will receive the consideration of our board at an early date."

From these reports it may be seen that most hospitals are not receiving full amounts from industries or insurance companies for hospitalized cases. Whether industry, the state compensation or the hospitals themselves are at fault is difficult to determine. From the wide range of charges it seems that the first step would be to obtain some logical basis of charge upon which payment can be computed, and then to take concerted action as advised in one letter. Local conditions and personal elements enter into many of the cases and superintendents are often powerless to make changes. But where a superintendent is accepting payment far below cost, knows that the payment is far below cost and that it is obtained from corporations well able to pay at least cost, and where there are no local conditions to render this payment just, he is keeping from the poor of his community proper treatment and is obtaining money from his contributors under false pretenses. People like to contribute to alleviate the sufferings of the poor, but there is yet to be discovered the man who will go down into his pocket to contribute \$10 to help the corporations to get cheap hospitalization for employees who need this care.

#### SOUVENIR BOOKLET FINDS FAVOR

A souvenir booklet of attractive design, which is being presented to mothers of babies born in the Harrisburg Hospital, Harrisburg, Pa., is answering a practical need as well as creating a pleasant impression in the minds of the mothers. On the first page spaces are provided for notes on the baby's arrival, showing the name, date, hour and weight. One page is provided for autographs. The footprint of the baby is placed here together with the autographs of the doctor and nurse. Pages are also included for registering the weights and after the mother and baby have left the hospital the book can be completed by the family by attaching a photograph of the baby and notes on its "First Outing," "Important Events" and "Gifts."



## CHICAGO TO HAVE NOTABLE MEDICAL EDUCATION AND HOSPITAL BUILDINGS

By Coolidge and Hodgdon, Architects, and Ralph B. Seem, M.D., Director, Albert Merritt Billings Hospital of the University of Chicago,  
Chicago

**T**HE Albert Merritt Billings Hospital, the Epstein Clinic, and the Medical Buildings of the University of Chicago will occupy that part of the university campus bounded by Drexel Avenue, Fifty-eighth Street, Ellis Avenue, and the Midway Plaisance. It comprises two city blocks.

Across the street are the laboratories for the pre-medical sciences and for the underlying sciences in medicine that are not included in the proposed group of buildings. This proximity will make it easily possible to maintain an intimate relationship between these departments.

### Units Housed in Separate Buildings

The buildings were designed with the idea of meeting the requirements for research and education in medicine and providing the best facilities for the care and treatment of patients. After a study of hospital conditions in this country and abroad, and seeking the advice of medical educators and research workers, it was felt that the requirements might best be met by adopting a plan that would provide accommodations for the different laboratory branches and the two main clinical divisions of medicine—medicine and surgery—in separate buildings that would be more or less complete in themselves, so that they might operate as units with a certain degree of autonomy.

While it was recognized that physical unity of departments was desirable, it was felt that they should not be too widely separated in order to secure correlation and coordination in their work, for the purposes of relationship with the public in the care of patients, and for economy and efficiency in operation to avoid duplication of services that might be used in common. It was also an essential part of the plan to provide for expansion of these units without the necessity of making changes in the arrangement of the buildings to be constructed at present.

In this group there will be five buildings, one for physiology, pharmacology and physiological chemistry, one for pathology, one for the medical clinic, one for the surgical clinic and the administration building, in which will be placed many services that will be used in common.

The building for physiology, pharmacology and

physiological chemistry will be built along Fifty-eighth Street and will not be directly connected with the other buildings of the group until intervening buildings have been erected. The buildings for the medical clinic and for the surgical clinic will be placed in the central portion of the plot so that additions may be made to either of them, not only for expansion of these departments, but to provide accommodations for related subjects. That is, adjacent to the medical clinic, space is available for the erection of the buildings for pediatrics, contagious diseases and psychiatry, and next to the surgical clinic buildings may be erected for departments related to it, as a women's clinic, ophthalmology and otolaryngology. In the medical building and surgical building, the space at the northern end will be used for laboratories and teaching purposes, while that toward the south will be used for patients.

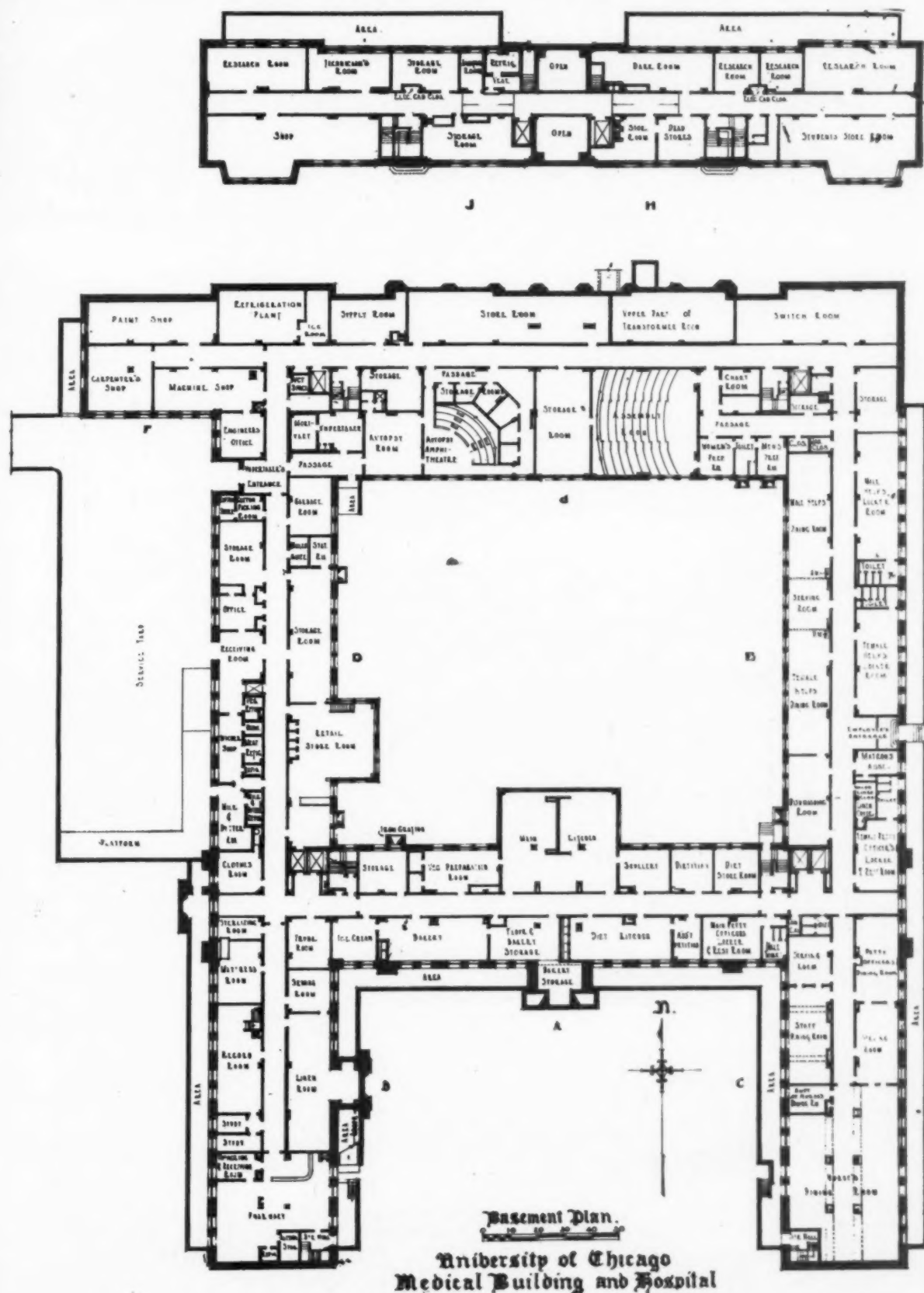
The buildings will be grouped about courts. Across the northern end of the plot will be the medical school court, from which entrance will be gained to the different laboratory buildings and to the laboratory sections of the medical and surgical clinics. This court will be largely used by members of the staff and students, those who will be more directly concerned in the educational features of the work. The building for pathology will be placed between the northern end of the medical building and the surgical building which are joined toward the south by the administration building, thus forming a large central court. The main entrance for the general public to the hospital and to the clinic for out-patients will be through the south central court which faces the Midway.

### Kitchen Is Centrally Placed

As the plans are self-explanatory no attempt will be made to describe them in detail, but only to point out those features that seem worthy of note.

The buildings will be six stories in height with a basement and sub-basement underneath the entire buildings, in which will be piping, ventilating ducts and machinery equipment. All stories above the basement will be eleven feet high.

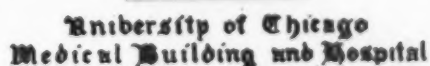
The basement, which is nine feet, six inches







A common record room will permit the establishment of a unit record system. The record room will be connected with the different departments of the out-patient, and also with the



wards throughout the hospital, by a pneumatic tube system for carrying patients' histories. The pharmacy, kitchen and other departments of the hospital will also be equipped with this system.

The ambulance entrance will be immediately adjacent to the admission department and to the elevators on which patients will be carried to the admission ward and to the emergency operating room, which are on the fourth floor.

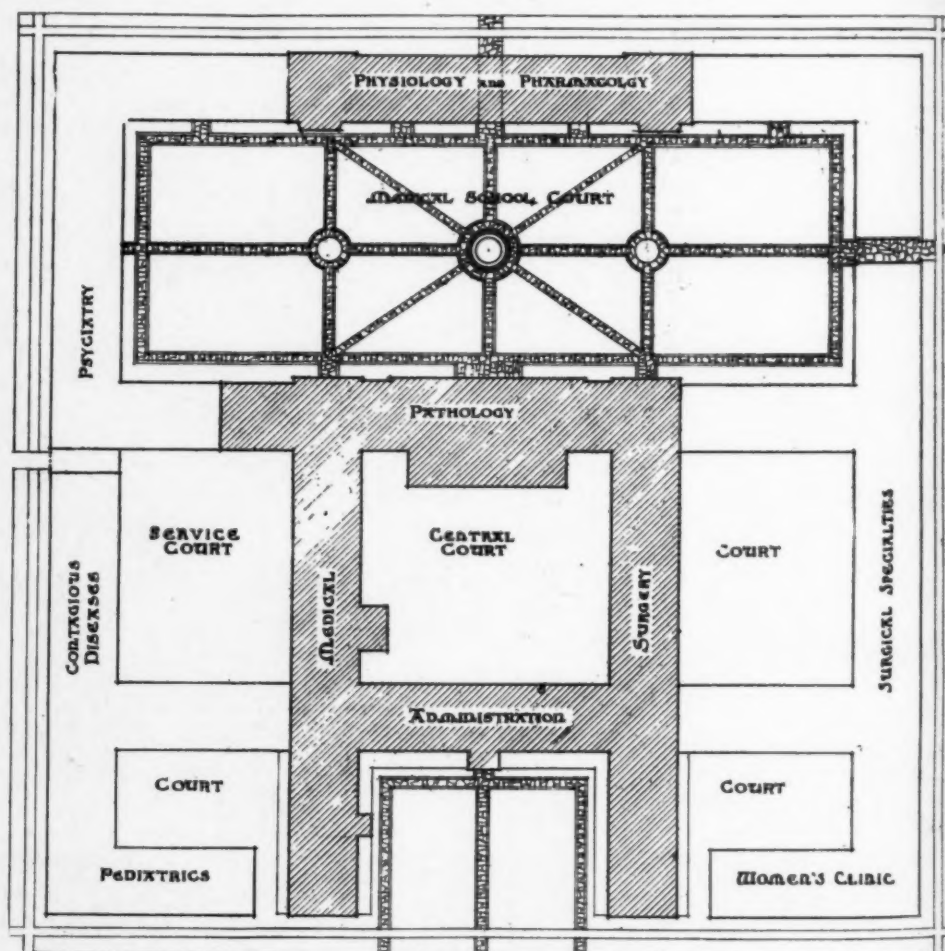
Most of the departments of the out-patient service will be on the second floor. The medical department and its divisions will be placed in the medical building and the surgical department in the surgical building immediately under their corresponding wards, so that a wide physical separation which is so often found between the wards and out-patient departments will be avoided. It is expected that the proximity of the different clinics to the wards will help to bring about a continuity of service for patients, so that they will be seen by the same members of the staff whether they are being treated in the wards or in the clinic. The whole out-patient department has been designed with the idea that it will serve as a diagnostic clinic so that when the conditions of patients permit, they will arrive in the ward partly or completely studied with the diagnosis made and with the treatment outlined.

The department of illustration and photography and the Frank Billings Library for current medical literature will be on the second floor of the pathology building. The living quarters for the resident surgical staff will be in the surgical building.

The hospital will have 216 beds distributed among nine wards which will be on the third, fourth and fifth floors. On the third floor will be twenty-two rooms for private patients, to be used by both the medical and surgical services.

There will be ten additional rooms in the medical wing, equipped with individual service for each patient, and this will be used for an isolation ward. On the surgical side will be a ward of twenty-four beds in one-bed and two-bed rooms for the surgical specialties. It was felt that this type of ward would provide the greatest amount of flexibility in the segregation of different kinds of patients that fall into this group. The corresponding space in the medical building will be used as a pediatric ward.

Typical ward units will be in the medical wing and the surgical wing on the fourth and fifth floors. Between them on the fourth floor will be the admission ward and on the fifth floor will be the x-ray department. It is intended that all patients except private patients will be admitted to the hospital through the admission ward. Emergency cases will be received here and also patients recovering from minor operations or the effects of special treatment given in the dispens-



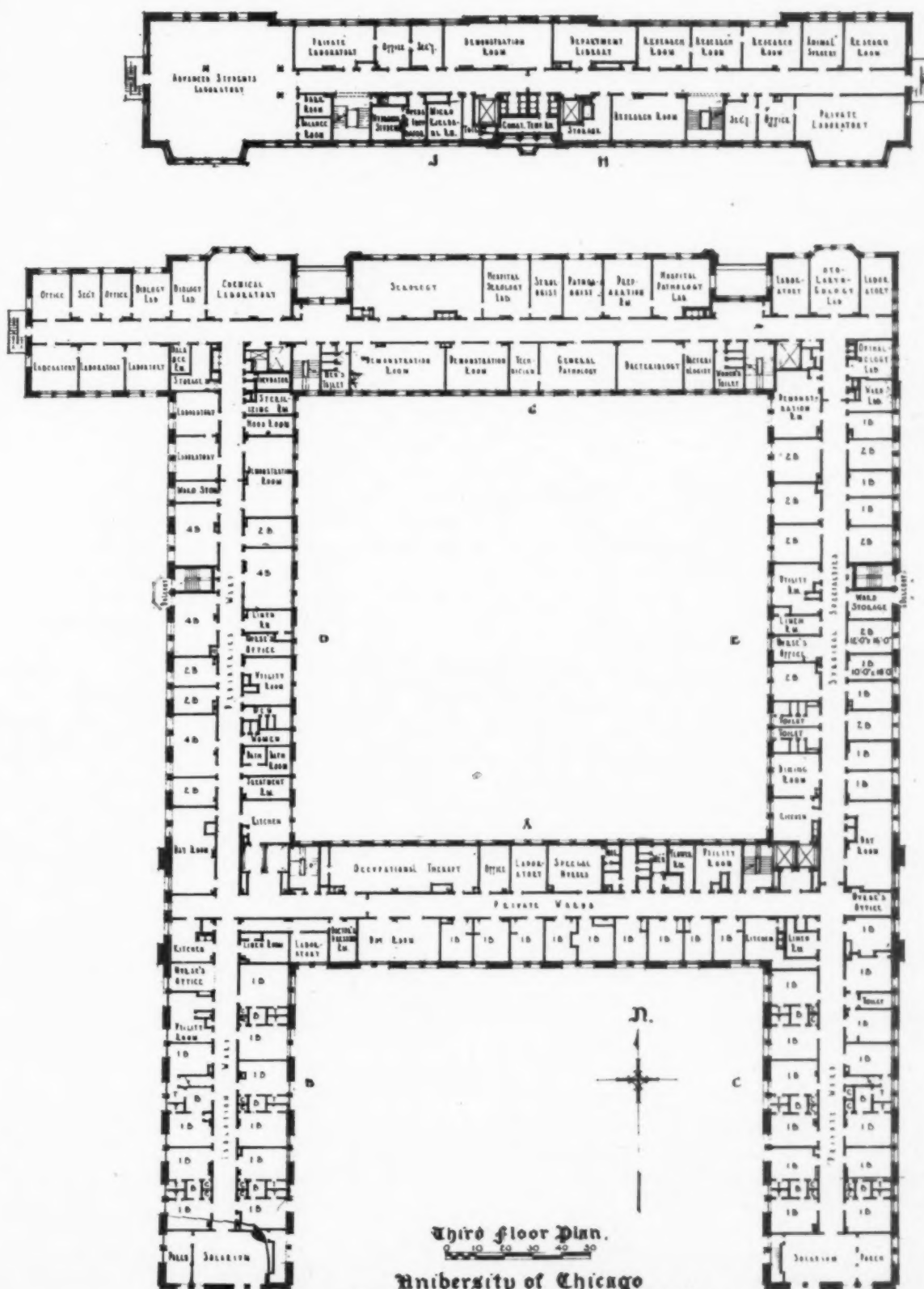
UNIVERSITY PLANS  
Plot Plan  
University of Chicago  
Medical Building and Hospital



ary, whom it might be desirable to keep under observation for a limited period. This ward will consist of eight single bedrooms, dressing rooms and bathrooms for men and for women, a room for the storage of patients' clothes and an emergency operating room in addition to the usual ward

service rooms needed for this size of hospital.

The typical ward unit will have accommodations for thirty-two patients, sixteen of whom will be in a large ward which is divided into four cubicles of four beds each. These cubicles permit a certain degree of segregation of patients and



Third floor Plan.  
University of Chicago  
Medical Building and Hospital



give them a privacy which they do not have in the large open ward. The beds will be placed at right angles to the long axis of the ward so that patients will not face the windows as they lie in bed. Beyond this ward will be a large solarium and also a balcony or terrace to which patients may be moved when it is desirable for them to be in the open air. The remaining sixteen patients will be cared for in one-bed and two-bed rooms. These accommodations will provide ample opportunity for the isolation and separation of as many different kinds of diseases and conditions as are likely to arise in the treatment and study of the various types of cases that will be admitted to the hospital.

#### Balcony Opens Off Nurse's Office

The service rooms and utilities for the ward unit will be centrally located. Next to the open ward will be the nurse's office, immediately across from the entrance to the elevators, so that visitors and patients coming to the ward will find themselves immediately at the nurse's office. Just outside the nurse's office will be a small balcony and porch for patients whom it might be desirable to keep under observation, when they are out of their rooms.

Of the two elevators to the ward, one will be reserved for passengers and the other will be used for service. This service elevator will open directly into the ward serving room.

At the distal end of the ward and connected with it will be a room where patients may be moved for demonstration to students and for special treatments and procedures that are always more or less disturbing to other patients when given in the large ward. It is expected that prepared trays for these procedures will be kept in a cabinet in this room so that these procedures may be undertaken without any delay beyond moving the patient to this room. The ward may also be entered from this end, which will connect it directly with the laboratories and other teaching activities. This approach will be largely used by students and members of the staff.

While some of the laboratories will be arranged and equipped to meet special needs, there will be a considerable number of rooms planned to accommodate four workers, and these will be arranged and equipped for doing any type of laboratory work. Some of these laboratories that will be immediately adjacent to the wards will be used by students assigned for work in the wards, so that the student will have a place almost in the hospital ward that he may regard as his own, in which he may carry on many of the duties in connection with his ward work.

On the sixth floor living quarters for the medical staff will be in the medical building, the operating rooms will be in the connecting wing between the medical building and the surgical building, and quarters for dependent activities to the operating room and laboratories will be in the surgical building. The operating rooms, of which there will be three, and a surgical amphitheater, will face the north. It should be noted that it will not be necessary for students to enter the operating rooms by the main service corridor but that they will reach the viewing stands from the landing of the east stairway between the sixth and the mezzanine floors, or by a special stairway from the mezzanine floor on which will be the entrance for students and observers to the surgical amphitheater.

The equipment of the buildings and the plans for the laboratory will be described in a later article.

The new buildings are being constructed of Bedford limestone, designed in modern Gothic, which is adapted to the functions and organization of the group. There has been a desire to rely mainly on composition of wall and void to bring about a decided architectural effect of graceful utility. Enrichment is confined entirely to carvings symbolic of the history and attainments of the science of medicine. Decorative lettering has been made to serve its part in the enrichment at points of vantage and interest.

#### Windows Are Divided in Small Panes

The windows will be mainly double-hung sash, with muntins dividing the glass into small panes. It is felt that this will secure a pleasing effect by carrying the value of stone across the openings which are necessarily rather large, four feet by eight feet with respect to masonry opening. It is hoped that this division of the otherwise somewhat garish large panes of glass into small panes will give a more cheerful and domestic atmosphere to the wards. The windows will give 20 per cent of the floor area in net light area in the wards and laboratories.

The dimension from the ground floor to ceiling will be nine feet six inches, and the other floors will be eleven feet to the ceilings.

The structural system will be mainly wall bearing with interior columns of reinforced concrete. Floor construction will be of the flat pan reinforced concrete type. The walls throughout the main group of buildings will be of terra cotta, finished with hard plaster, all re-entrant angles being coved. While the laboratories will be left with terra cotta partitions and concrete ceilings exposed, the corridors, elevator shafts, stairways

Terrazzo will be used throughout for stairs, and floors of corridors, toilets and utility rooms. In the ward sections the field of corridors will be rubber tile. The floors in open wards will be

laid with rubber tile. The main waiting room of the out-patient department will be laid with tile, corridors and expansions of the corridors which will be used as waiting rooms will be terrazzo, the rest of the floors in the out-patient department will be mastic. Tile floors will be used





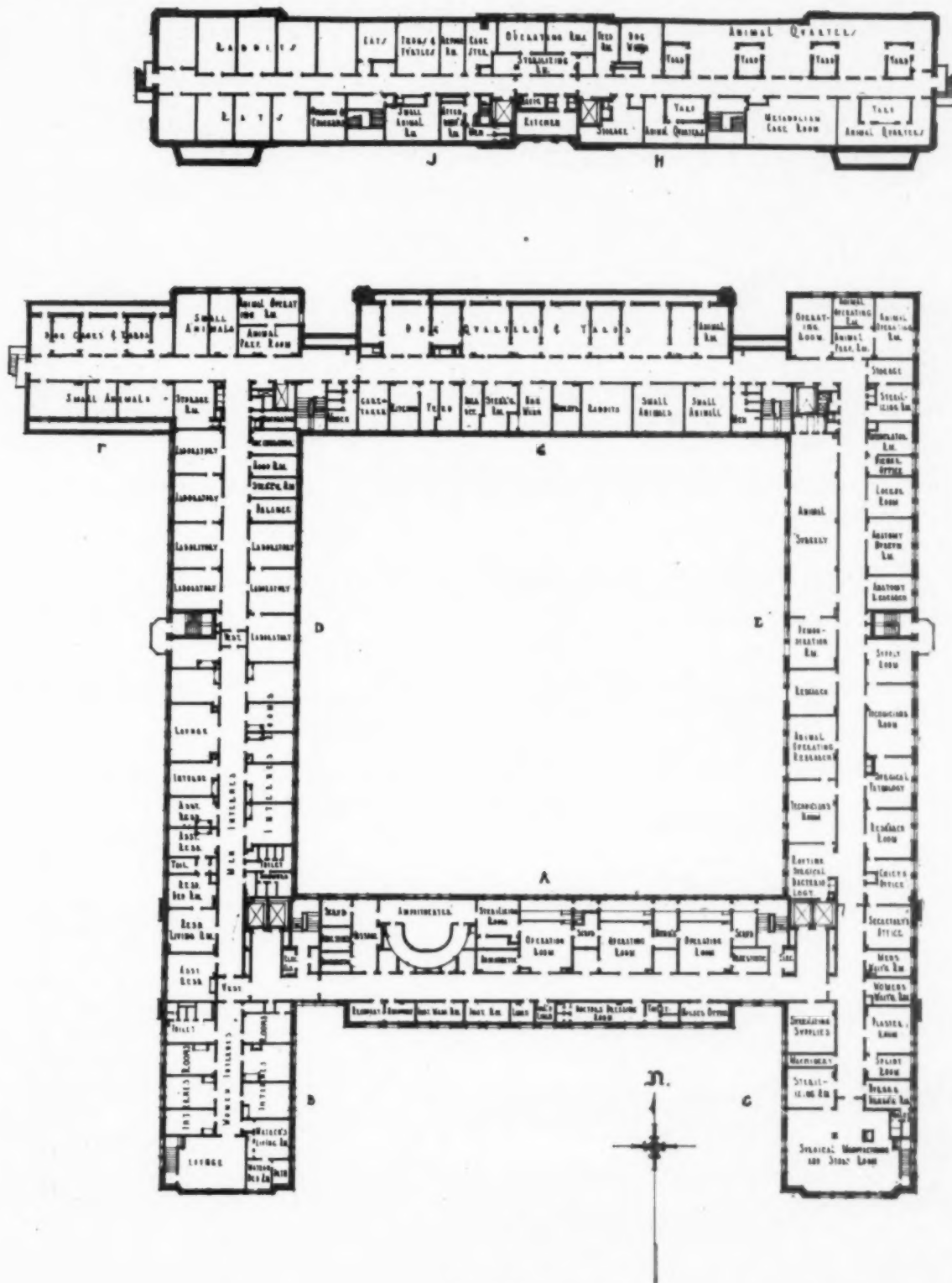


in use.  
several  
p. All  
b-base-  
entire  
will be  
installa-

tion over a system of tunnels or pipe trenches with their cramped working conditions. All these services will thus be accessible at all times without any disturbance to the main basement, another factor of economy well worth considering.

The refrigerating system will be maintained by a duplex carbon dioxid compressor, direct expansion type. Ice water will be cooled by this system and distributed to the wards.

Great care has been exercised in the planning



Sixth Floor Plan.

University of Chicago  
Medical Building and Hospital





and design of the laboratory fittings. These have been standardized as much as possible so that there will not be more than a few differing types of units. Alberene tops will be generally used for chemical tables.

### Physical Areas

The length of the main building from north to south will be 579 feet, and from east to west, 254 feet.

The cubic contents of the building will be as follows:

Main Group of Buildings .....	5,434,395
Laboratory Building .....	1,226,205
	<hr/> 6,660,600
Pathology Building .....	886,800

### Relative Size of Departments

The figures given below show the areas of departments, inclusive of interior partitions, corridors, stairs and other services.

1. Main Group of Buildings .....	401,563
2. Administration .....	33,972
Includes lobby, administration offices, staff living quarters, admitting offices, record room, pharmacy, social service.	
3. Service (throughout) .....	69,812
Includes main kitchen, bakery, diet kitchen and adjuncts, main hospital storage, including pharmacy, food, linen, books, mattresses, patients' clothes, help's locker rooms and dining rooms.	
4. Out-patient Department .....	28,308
Includes all the regular dispensary departments, including hydrotherapy, occupational therapy.	
5. Wards .....	71,357
Include all public, private and isolation ward units, solariums, connecting corridors and open wards.	
6. X-Ray Department .....	7,678
7. Operating Suite .....	10,724
8. Surgical Laboratories .....	28,548
Includes all laboratories situated in the main group of buildings devoted to surgery.	
9. Medical Laboratories .....	45,129
Includes those situated in the main group that are devoted to medicine.	
10. Pathology Building .....	56,400
11. Laboratory Building .....	97,070

### ONE WAY TO CHECK GROWING COSTS

One hospital administrator who has long compiled accurate statistics and made use of graphs, found the costs of his x-ray department mounting at a rapid rate. Expenses in no way kept pace with income, and the advance was so abrupt and marked that he conferred with the x-ray department head. When told that the costs in the x-ray department had increased nearly 40 per cent within sixty days, the department head was inclined to disagree. His protest was instantly overcome by the presentation of a graph that clearly showed the trend of cost performance of that department since its inception.

Subsequent discussion of department practices revealed that fact that the department had almost entirely abandoned the use of small films and were taking all pictures on large plates. Furthermore, where formerly two positions of a bone were taken on one film of small size, the newly employed assistant was using two large size films to accomplish the same result. Out of this consultation came the recognition of the necessity for using, whenever possible, films of small size, and when practicable the double exposure of every film. If the superintendent had not had access to accurate statistics and graphs kept up-to-date in every detail, the increased costs in the x-ray department would probably have continued unnoticed.

### An Intern's "If"

THE following poem—a parody on Kipling's "If"—recently appeared in the "Tonics and Sedatives" column of the *Journal of the American Medical Association*. The poem applies to many of us as well as the intern.

If you can get to work when all about you  
Are all at sea and don't know what to do;  
Stand by your diagnosis though they doubt you,  
Yet, being wrong, can change opinion, too;  
If you can take the "buck" they pass you without fussing,  
Yet when you're House-Man never do the same,  
Or being "cussed out," don't give way to "cussing,"  
And yet don't look too fierce, nor yet too tame;

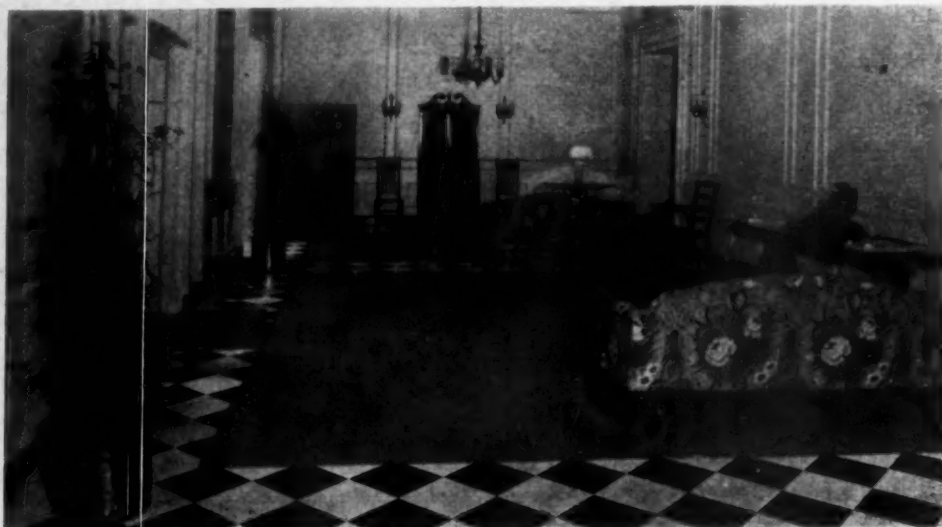
If you can think but end your thought in action,  
If you can act, but think and plan it, too,  
If you can meet with either Death or Satisfaction,  
Nor let one crush, the other exalt you;  
If you can miss the night's sleep yet be cheerful,  
As you go about the next day at your work,  
If the unexpected finds you are unfearful,  
And the drudge and "scut-work" find you do not shirk;

If you can hear an old man's talk and be condoling,  
Yet know the thoughts and fancies of the child,  
If the mother's fears can find you well consoling,  
And people's scorn and anger leave you mild;  
If you can shoulder blame and not relay it,  
If you can see them turn your plans all wrong,  
And, being disappointed, don't display it,  
Yet make your comment where it does belong;

If you can "get along" with Nurse and "Super,"  
And like them all, yet love but only one,  
If you can do some work that keeps you waiting,  
And withhold your judgment till your work be done;  
If you can let your work advance another,  
If you can eat an intern's meal without complaint,  
You'll be a real good intern, brother,  
In fact, you know, you'll almost be a saint.

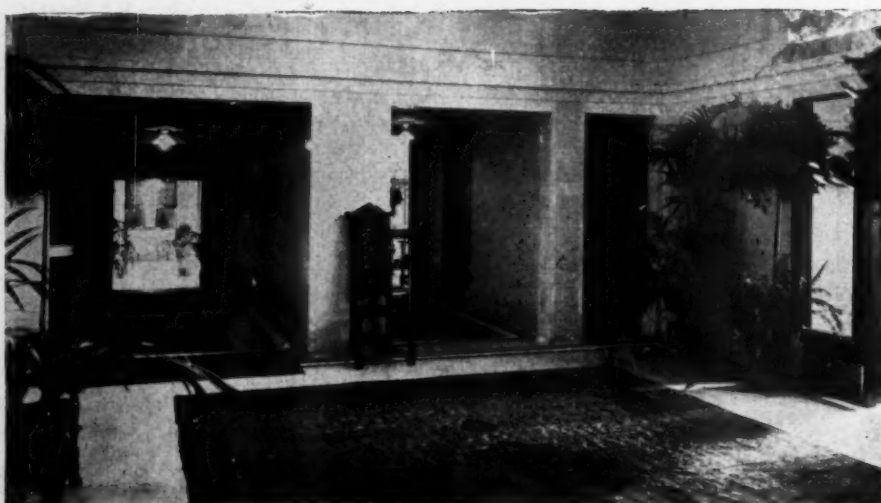
B. ASHE, N. Y.





*Three  
Lobbies  
of the  
Newer  
Order*

*Above, the main lobby of the Maternity Hospital, Cleveland. On the right, a view of the lobby of Evanston Hospital, Evanston, Ill., showing a pile of the hospital's annual reports.*



*On the left, the lobby of Grant Hospital, Chicago, an institution of 150 beds.*

# LABORATORY TECHNICIAN AS A VOCATION FOR CARDIOPATHICS

By Max Kahn, M.A., M.D., Ph.D. and Joseph Barsky, M.D., Attending Physicians, Beth Israel Hospital, New York

**T**HE lot of the cardiopathic is a hard one for Nature has given him a chronic ailment from which he can hope for no release until death, and this liberator may be long in coming. So he remains alive, a panting, gasping individual, threatened with periods of decompensation should he engage in any pursuit that puts an undue strain upon his cardiovascular system.

There are few occupations open to cardiopathic individuals, and therefore many of them become a burden, supported by their relatives or by public charity. This plays havoc with their pride and with their social contentment, and is reflected in their state of health. Many of them are intelligent, educated people to whom the very idea of dependence is mental agony.

Occupations or professions must have certain qualifications before they can be recommended for a cardiopathic. Such vocations must not require great physical strain or the exertion of hurrying or rushing the accomplishment of a task. The hours of work must not be excessive. The surroundings must be cheerful, pleasant and quiet. The employers should appreciate the conditions under which these workers labor and should not overtax them, or urge them to greater labor by a command to "hurry up."

## An Answer to the Problem

These qualifications are fully met by the profession of laboratory technician. There is a demand for such workers all over the United States. Many of them are wanted for only half-day work, and thus the weaker individuals could find ideal employment.

The Beth Israel Hospital has trained, without any tuition fee, many normal young men and women for the vocation of laboratory technician. Many of them have left the city and have found responsible and paying positions in distant states. A few have been trained who were suffering from some physical defect; they, also, have found lucrative situations in New York and other cities.

It is perfectly feasible to take certain, young, intelligent cardiopathic individuals, recommended to us by the department of cardiac diseases, and train them to become reliable and capable clinical laboratory technicians. During their course of study, their family or the social welfare department should find means to support them. They

should be periodically examined by the cardiologist so that their health may not be impaired during the months of training.

It may be necessary for the hospital to engage certain instructors to teach the pupils history taking, record keeping and typewriting, so that a certain number who graduate will be qualified to become office assistants to doctors. These latter will be taught only the amount of laboratory technique necessary to fit them for routine examinations in a physician's office.

## Two Classes of Vocations

Thus, two classes of vocations will be opened for the cardiopathic: (1) laboratory technician, a course that will take between eighteen months to two years to accomplish, and (2) office assistant, a course that can be completed in nine months to one year.

The curriculum of the course for laboratory technician is given below. Suggestions for modifications and improvement will be welcomed.

The social welfare department ought to welcome such a plan whole-heartedly because it is a progressive step in the professional education of sub-physically fit individuals. In fact, the establishment of such a system of education in our hospitals, would be, in my opinion, of historic import in the care of cardiopathic individuals.

## Course of Laboratory Technician

*Duration—two years, six days weekly. One month's vacation yearly.*

### SUBJECTS

#### Urinalysis

Lectures ..... 10  
Practical work (chemical and microscopical) 2 months

#### Hematology

Lectures ..... 5  
Blood counts.....2 months

#### Serology

Lectures ..... 10  
Venesection ..... }  
Wassermann test ..... } 3 months  
Widal test ..... }  
Colloidal gold test ..... }  
Blood grouping ..... }

#### Bacteriology

Lectures ..... 10  
Smears ..... }  
Cultures of throat, feces, sputum, urine, etc.. } 3 months  
Vaccine preparations ..... }  
Blood cultures ..... }  
Identification of bacteria ..... }

#### Pathology

Lectures ..... 4  
Preparations of sections ..... }  
Autopsy ..... } 2 months  
Frozen section preparation ..... }  
Museum work ..... }



Chemistry	
Lectures .....	10
Quantitative urine work (glucose, albumin, nitrogen, sulphur, calcium, etc.) .....	
Blood chemistry .....	2 months
Enzyme analyses .....	
Milk analyses .....	
Feces analyses .....	
Cerebrospinal fluid .....	
Exudates and transudates .....	
Toxicology	
Lectures .....	2
Analyses for mercury, carbon monoxid, lead, arsenic, morphine and strychnine .....	1 week
Basal Metabolism	
Lecture .....	1
Technique .....	1 week
Functional Diagnosis	
Lectures .....	6
Phenolphthalein test .....	1 month
Tetrachlorophthalein test .....	
Sulfo-conjugation test .....	
Gastric analyses (Rehfuß) .....	
Duodenal analyses .....	
Lyons-Meltzer test .....	
Alveolar air analyses .....	
X-Ray	
Lectures .....	6
Technique .....	4 months
Cardiography	
Lectures .....	2
Technique .....	2 weeks
Photography	
Technique of camera and plate development .....	1 month
Record Keeping	
Practice	
History Taking	
Lectures .....	1 month
Practice .....	

### HOSPITALIZED

"Through the zeal and idealism of some of the poor house directors, superintendents and physicians, widespread efforts are being made to convert the almshouse into a general hospital, not only for the best possible care of the aged and infirm who may be inmates, but also for the care of those chronic cases, contagious disease cases, venereal and tuberculous cases that cannot be cared for in most of our smaller city hospitals.

"We should like to point out here that from 30 to 50 per cent of the total population should be provided with hospital care. That means that from one-third to one-half of the institution must be given over to bed patients. There must be some operating facilities, dispensary, utility room and diet kitchen. Small, quiet rooms off the hospital wards must also be provided for ill patients.

"Bed facilities should be those of ordinary hospitals, but provision should be made for air beds or water beds, beds that can be cranked up for changing the position of patients and other special appliances for cure.

"The smaller almshouses in which complete hospitalization would be extremely difficult nevertheless must make suitable provisions for the chronically ill and infirm. There should be infirmaries or sick wards. For any but the smallest institutions, infirmaries should be subdivided into a large ward, which may hold from four to ten beds, and a small adjoining room suitable for a single patient.

"No acute cases should be treated in the almshouse if it is possible to avoid it. General hospitals should care for cases of syphilis in the first and second stages and all other diseases, injuries, etc. Gonorrhea should never be treated in the almshouse."—*Emil Frankel, special representative, state-wide survey, Poor Relief in Pennsylvania, Bulletin 21.*

### BERLIN'S HOSPITALIZATION PROBLEM

Professor Hoffmann, director of the central public health bureau of Berlin, Germany, has outlined the problems concerned with the hospital service. Municipal, private and state hospitals are all filled nearly to capacity. Greater Berlin has 21,700 beds in institutions for the sick, including orphan asylums and municipal shelters—more than five beds for each thousand inhabitants. The proportion was adequate in the pre-war period, though some cities had six and seven beds per thousand inhabitants. Difficult housing and living conditions, notwithstanding the favorable status of the general health, account for the hospitals of Berlin being nearly always filled to capacity. Surgical and medical adult departments are especially crowded. The *Zentral-Bettennachweis* is kept informed by telephone of the beds available in the various hospitals, and thus far this central bureau has usually been able to meet demands for hospital accommodations. The difficulties will, however, increase as the population of Berlin continues (mainly as the result of immigration) to grow. Old Berlin had three general hospitals. However, the suburbs that in recent years have been incorporated in Greater Berlin were not well supplied with hospital accommodations. Recent statistics show that there is an ever increasing number of aged persons seeking admission to hospitals. January 1, 1930, there will thus be approximately 8,000 invalided persons to provide for. Unfortunately, the accommodations for old people are especially inadequate.

Of equal importance is accommodation in the coming years for the increased number of psychopathic patients. Following the war, owing to bad housing conditions, few psychopaths continued to be cared for at home; furthermore, the reduction of alcoholism was only temporary, and, finally, a number of private institutions closed because of bad financial conditions. January 1, 1921, the number of mentally ill patients in Berlin was 4,921 and in the provincial institutions 1,718; January 1, 1925 the numbers had increased to 5,616 and 3,662, respectively. January 1, 1930 there will be presumably 11,800 psychopaths. As the beds for psychopaths provided in the province cannot be used by the city to the same extent as formerly the psychopathic institution in Buch, which, in 1919, was transformed into a children's hospital, will have to be restored to its former use.

Another consideration is for more accommodations for tuberculous men. When, a few years ago, the so-called *Heimstätten*, or homes, were discontinued, tuberculous men were sent mainly to private institutions. It was decided, as a first measure, to enlarge bed capacity of the Charlottenburg "Forest Home" (*Waldhaus*) from 300 to 600. In addition, an endeavor will be made to provide other buildings in favorable locations.—*Journal of the American Medical Association.*

### AVERAGE STAY OF PATIENT

One of the most remarkable signs of progress that hospitals have made during the past twenty-five years is the great decrease in the average length of stay of patients. Twenty-five years ago the average person going to the hospital was certain that he could not return home in much less than a month, for thirty days was the average stay at that time.

Today the average patient is home and practically recovered twelve days after he enters the hospital unless his case develops a complication.

## HOW CONSTANTINOPLE HOUSES ITS MENTAL CASES

By Clarence Richard Johnson, Formerly Professor of Sociology, Robert College,  
Constantinople, Turkey

CONSTANTINOPLE has three institutions for the mentally ill; the Greek National Philanthropic Institution, the Armenian National Hospital and the Turkish Insane Hospital.

The Greek National Philanthropic Institution, the best equipped of the three, is located at Yedi Koule, a suburb of the city, and occupies an extensive site outside the land walls of Constantinople. It is situated about fifteen minutes' ride from the railroad station behind the historic Seven Towers and only twenty minutes distant from the Sea of Marmora on the south. The institution has spacious grounds with many trees and with well cared for gardens. The insane asylum is only a part of the institution, for there is also a pathological clinic, an asylum for the old and a surgical clinic, each with one or more separate buildings.

Statistics for the year 1922 show that there were 279 mental cases cared for here. Of these, 217 were Greeks, but Ottoman subjects; fifty were Greeks, subjects of Greece; and the remainder comprised six Russians, two Italians, one American, one Albanian, one Serbian and one Spaniard. One hundred ninety-five of these entered in 1922, eighty-four of the total number having remained from the preceding year. Fifty were discharged cured, fifty-seven were discharged somewhat improved, fifteen left as they entered, and forty-two died.

Of the 279 inmates, fifty were married, seventy were bachelors, twenty-two widowers, and 137 boys and girls under the age of twenty-one.

The physician in charge listed the following as the causes of insanity of these patients:

Nervous disorder .....	149	cases
"Intermittent madness" .....	60	"
Degeneration .....	20	"
Epilepsy .....	15	"
Persecution mania .....	13	"
Syphilis .....	12	"
Alcoholism .....	10	"

The men's department is in a two-story stone building. Patients who are not violent are kept in dormitories that have iron beds as the only furnishings. There is a special dormitory with

thirty beds where patients suffering from melancholia and those who show tendencies toward suicide are kept under observation. The inmates are allowed to walk in the adjoining garden when the weather is favorable.

Similar in structure is the building for women. Most of the women are provided with beds, although in some dormitories through a lack of beds, a few patients are compelled to sleep on the floor. For violent patients small rooms are provided wherein patients are locked alone and guarded closely.

Situated among high poplar trees in a beautiful little park with fountains and bright flower beds, are seven cottages consisting of two or three rooms with private bath in which pay patients are housed. These rooms cost four liras (\$2.50) a day. These inmates are considered as first class patients. The patients in class two have private rooms but often there are two people in the room and each one pays two liras and a half (\$1.65) a day. The inmates of class three

are in large wards and pay only one lira a day. The fourth class are free inmates housed in large wards, and the fifth are unclean idiots who are confined in a ward fairly well lighted and well ventilated.

### Administrative Officers

The hospital is in charge of a physician who is a specialist in insanity, assisted by one intern. A few of the patients are employed in light labor about the grounds and buildings, although most of the patients sit about unoccupied. This hospital, like the Armenian hospital and the Turkish Asylum, serves as a means of restraining mental patients, but none of the modern curative methods found in our large asylums in America are in use.

The Armenian National Hospital, with a section for mental patients, is also located at Yedi Koule not far from the National Greek Philanthropic Institution. Most of the inmates are kept in large wards, although there are special rooms



Kitchen building, Greek National Philanthropic Institution, Constantinople.





Building housing pathological clinic.

for pay patients. Patients may associate with each other unless they are unmanageable. Violent patients are confined in wards under a special guard and at the time this hospital was visited in May, 1921, by an investigator for "The Pathfinder Survey of Constantinople," one patient was seen in a straight jacket. The wards are light and airy and fairly clean, except where the imbeciles are confined. This ward is in a dark hall very poorly lighted and ventilated. At the time of the visit the air was bad and the tile floors had water standing in spots. This ward has already been severely criticized and a new one is to be set aside for the unfortunates very soon.



General view of hospital buildings and grounds for the mental cases.

Of the 104 inmates, all Armenian, 88 per cent are free patients and 12 per cent are full or part pay. Among the patients are a few who had been deported during the War and who, because of hardship endured in the desert, lost their mental equilibrium.

#### Tasks Allotted to Patients

A fairly large number of the patients are employed in various parts of the hospital and are reported to be reliable in their work, some of them being intrusted with tasks of no small importance. One, for example, is in charge of grounds and buildings and another has the task of issuing bread daily to the various departments. Accord-

ing to the warden, this man never makes a mistake and keeps count of the number of loaves with remarkable accuracy, but when at liberty he dances about the halls with his bread basket, and talks incessantly and unintelligibly. But as yet there is no attempt made to keep the inmates employed or interested while in the wards.

#### Scutari Government Hospital

The Turkish Government Insane Hospital at Top Tash in Scutari, on the Asiatic side of the Bosphorus, cares for ninety-eight women and 170 men. In this institution, as in the Greek and Armenian asylums, the men and the women are kept absolutely segregated in parallel establishments. Here they are housed in an ancient building, once the barracks for the Janissaries some three hundred years ago. It is rather damp and cold with stone floors throughout. Here all poor patients are accepted free, but thirty-six patients with means pay for their keep. The management accepts patients regardless of race, and Armenian, Greek and Jew are identified among the patients, most of whom, however, are Turkish. In addition to these patients there are a few mental cases in the Turkish Poor Farm located at Chichli, a couple of miles outside the city, and it is probable that a number of mental cases are cared for in

their own homes, for the three institutions together have a population of less than 700, a number which is rather small for a city having over a million people.

The Turkish Insane Hospital, while not so fortunate with respect to housing facilities, is in the lead in occupational work, as the staff of Turkish doctors has recognized the importance of industrial training and has opened a tailor shop, a shoe shop, and a carpenter shop. Here work and training on a small scale is provided especially for juvenile inmates of whom there are a small number. In this way an attempt is made to keep the patients employed and interested while they are in the hospital.

## MEASUREMENT OF SOCIAL PROGRESS

### A Plea for Pathometry

By E. H. Lewinski-Corwin, Ph.D., Director, Hospital Information Bureau of the United Hospital Fund of New York

IN THE economic, political, educational, intellectual and artistic spheres of activity, social progress can and has been measured in rather definite if crude terms of advancement: in the growth of the per capita wealth, in the percentage of votes cast at presidential elections, in the number of high school and college graduates, in the sale of books for the "intelligentsia," in the number and types of concerts and art exhibits and so on. Social progress has milestones by which the velocity of its onward march can be gauged in terms of aspiration, achievement, and the creation of new values.

There is one phase of social progress which in its manifestations is negative and suppressive. We start out with certain existing evils or social ills, and our measure of progress is the extent to which these evils and conditions can be diminished or obliterated—dependency, delinquency, illegitimacy, orphanage, truancy, mental deficiency, bad housing and the like. We are interested in providing gauges for the success we have in suppressing social evils, whether environmental or hereditary. We ought to do this in order to appraise the value of our endeavors and to justify the costs involved.

A great deal of our social work endeavor is based on an empirical foundation. We want to establish for it as much scientific justification as is possible by a statistical regimentation of the objective attributes of the phenomena we are dealing with. In other words, we want to establish a social balance sheet of debits and credits. We have not done it as well as we might have.

Even in the field of public health, which has been fairly well surveyed, there is a great deal of opportunity for improvement of the statistical data, as well as for developing gauges of the value and rationale of many of our procedures. What is the precise value of medical school inspection in the cutting down of communicable dis-

eases, in the repair of defects, in the establishing of health habits and in reducing absence of school children, among each 1,000 pupils? What is the value in similar terms of the various health conservation centers? To what extent does mental hygiene work reduce the prevalence of some of the preventable psychoneurotic disturbances? It will require a long series of careful analyses of

the work performed before any approximation of the exact value of certain of our public health functions can be established. It may not be worth the investment from the point of view of those who do things in a missionary or reform spirit, but it certainly would be worth while from the point of view of scientific allotment of the community budget for public health work.

If the future is to be as roseate as most of us like to picture it,

people will look back at our efforts to do things in a haphazard way with the same feeling that we now entertain toward those who tried to deal with the various phenomena in medicine, let us say, in the pre-Pasteur era. We are satisfied with "muddling through." Take the problem of prolonging life. I, for one, am not interested in longevity *per se*. When we speak of our efforts to postpone death, we sometimes forget that the basic philosophy underlying it is not the mere attainment of a longer span of life, but a prolongation of usefulness to society, as well as the longer enjoyment by the individual of the physical, emotional, mental and recreational pleasures and powers of life. Extending life without protecting it from the cross of invalidism or of disease is not rendering a great social service.

Mortality statistics, therefore, are only a very crude gauge of social progress, viewed from this standpoint. It is true that mortality statistics serve as an index to disease, but the fact alone that 50 per cent of mortality is due to chronic diseases renders the lethal rate an inadequate index of

### Establish a Clearing House

IT SEEMS incredible that we have no data with regard to the health capital of our communities. The agencies and individuals dealing with illness have never been asked to clear their experience through a central agency, as the banks dealing with our money capital do. If all the hospitals, dispensaries, and private physicians were asked to make annual reports of the amount of sickness they deal with during the year, they would resent this. And yet a beginning has to be made and in due time there will be no more resentment of clearing the data in illness than of clearing bank accounts today.



health achievement. Morbidity statistics are a much superior indication of real and positive progress in this respect. Properly organized morbidity statistics would give a clue to important questions. Some disease conditions are due to heredity, others to environment, and still others to both—a hereditary diathesis under certain given environmental conditions. What progress are we making in dealing with these various types of diseases? Are they increasing or decreasing, and at what rate per 1,000 of population?

With regard to the environmental factors of disease, it is important to know at what ages breakdowns due to various diseases occur. The need of such information for practical purposes came to my attention only a short while ago. A large donation was given to one of the relief agencies to establish among other things, a "preventorium" for adults. The question arose with regard to the age groups of prospective clients for such an institution. There is no information bearing on the subject.

Then again in the field of industry, occupational morbidity is a more valuable gauge of social progress than occupational mortality. It is also a better indication for the need of community action.

### Need for Health Data

It seems incredible that we have no data with regard to the health capital of our communities. The agencies and individuals dealing with illness have never been asked to clear their experience through a central agency, as the banks dealing with our money capital do. If all the hospitals, dispensaries, and private physicians were asked to make annual reports of the amount of sickness they deal with during the year, they would resent this. And yet a beginning has to be made, and in due time there will be no more resentment of clearing the data in illness than there is today of clearing bank accounts.

The beginning can be made only with the aid of progressive medical institutions. The morbidity statistics of hospitals could not only be made to acquire social significance, but they could be made likewise of value to the institutions supplying them. They would raise a number of questions with regard to the character of work that is being undertaken and the results obtained. If the comparative statistics of hospitals, similar to financial statistics, were published annually, giving the end-results of operations, the results to mothers and babies of various types of delivery procedures, and other similar data, it would make the physicians, the boards of trustees and the administrators more alive to their problems.

We speak of the value of the out-patient department in the prevention of disease, but we have not made any studies and we have not planned any studies of how many of the patients that attend the dispensaries come merely for a physical examination to discover incipient disease, and what proportion come to seek relief for ailments. If we do not start to make such studies and do not make them at definite periods, we shall never be able to answer the question of what progress we are making in utilizing our institutions for health building purposes.

As I stated at the beginning, there is a great deal yet to be done in the field of public health before a real measure of social progress in this domain is applied. This, in brief, is the case for pathometry, or the science of disease phenomena in the community.

### FIFTEEN WAYS TO SAVE COAL

The following list of fifteen ways to save coal embodies the essential points for the guidance of hospital engineers and janitors.

1. See that fire beds are kept at the proper thickness.
2. Avoid all holes in the fuel bed.
3. Avoid unnecessary leaks of air into the combustion chamber.
4. Repair leaky flues or pipe connections promptly.
5. Watch the brickwork, and the fire and dust doors, for air leaks.
6. Make sure all dampers are in good working condition.
7. Keep the boilers scale-free and the combustion chamber soot-free. One hundred pounds of scale will waste four hundred pounds of coal every twenty-four hours.
8. Make sure all baffles are working properly.
9. Open fire or observation doors as little as possible.
10. Make sure of an even flow of fuel.
11. Make sure all insulated pipe is covered properly.
12. Maintain normal boiler pressures.
13. Feed water heaters and pumps should be kept in good condition.
14. Keep the feed water at the maximum temperature. Ten degrees in feed water temperature equals one per cent in fuel.
15. Control drafts so that safety valves do not waste steam by "blowing off."

### SPECIAL MAIL SERVICE OFFERED

The ancient adage, "It is the little things that count," is more true with the sick than with any other class of people. One of the appreciated "little things" in a well-known French hospital is the practice of delivering all patient's mail in a special large envelope. Because of this the patient feels that added attention to the mail assures prompt delivery and prevents loss. The patient appreciates the fact also that his mail is withheld from the curiosity of those who deliver it. The envelopes are not sealed but are fastened with string and the folding brass holders. In this way one envelope will serve a patient throughout his entire stay in the hospital.



## MARIEMONT'S PLAN OF HOSPITALIZATION



By H. P. Van Arsdall, of Samuel Hannaford & Sons, Architects, and Charles J. Livingood, President, The Mariemont Company, Cincinnati

**E**SPECIAL interest attaches to the hospital group for Mariemont, Ohio, as it forms one unit of the most unusual real estate developments ever attempted in this country.

Mrs. Mary M. Emery, one of Cincinnati's benevolent and philanthropic citizens, conceived the idea of building a "complete city," where a self-respecting citizen of average means could establish a home, under the most healthful and favorable conditions. The magnitude of the undertaking was unfolded some years ago, when a corporation was formed known as The Mariemont Company, having an authorized capital of \$5,000,000, with Mrs. Emery sole owner.

After tedious negotiation the company acquired 420 acres of fertile farm land, situated on a well-drained plateau, overlooking the Little Miami Valley, just nine miles east of the Cincinnati business district, and within two miles of the Eastern suburban residential section.

### Needs Studied by Town Planners

At the outset an eminent firm of town planners was retained and Mrs. Emery and Mr. Livingood impressed upon them that it was not their purpose to create a Utopia but a convenient town practical in use, and charming in its physical aspects. With this in mind the problem was studiously attacked, and by careful and painstaking effort an ideal city was laid out to care for a present population of 9,000, with possible expansion to 20,000.

The main portion of the city is laid out in an octagonal form, with thoroughfares radiating from its center and extending to the residential sections. Around the town center, within easy walking distance is a non-denominational, memorial church for the use of all faiths; a town hall, theatre, banks, school, office building, post office, public library, museum, markets, and shops of all

sorts. As a gift to her fellow citizens, Mrs. Emery will provide a stadium, recreation field, and fifty acres of parks and playgrounds. It is not proposed to make the city a philanthropy, but to conduct the development along lines such as any normal real estate concern would pursue, expecting a reasonable return on the investment. For the present Mariemont will be a residential village, with provision for a future industrial district.

### Thirty-Six Architects Employed

The services of twenty-six architects have been employed in designing the various buildings, with each firm doing the class of work for which it was best fitted. In the building of the city, the usual practice of tearing up streets when buildings are erected has been forestalled, as all utilities such as sewers, water and gas mains, electric and telephone lines, etc., were extended underground to each lot prior to the street construction. For the benefit of the public, every necessity and convenience has been provided, such as schools, parks, athletic fields, and last, but of major importance, the hospital group.

Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, acted as consultant.

In the northeast section of the city, on a wooded knoll, beautifully situated, it is planned to build the hospital group. The center or main building is now under construction, and will in itself be a complete institution containing all the essential features of a general hospital for a community of the present size. This building is of fireproof construction, 53 feet wide, by 142 feet long, four stories high, and contains thirty-three patients' beds. In harmony with its surroundings, the exterior of the building is treated in the Colonial style. The walls of the ground floor, forming the base of the building, are of native hill limestone,





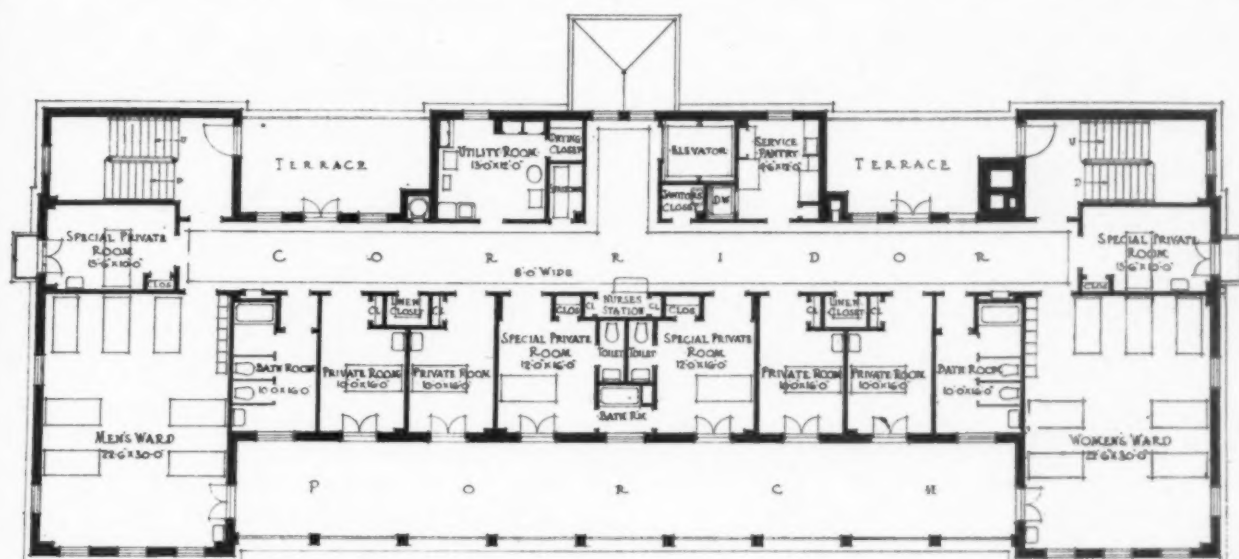
cian, on the right of the entrance. Directly in front of the entrance is a large reception room with doors leading onto a spacious porch extending across the south front of the building. On the first floor is located the general office, superintendent's office, staff and board room, resident physician and superintendent's living quarters, head nurse's office, children's ward and isolation ward and the necessary dependencies. The children's ward has its own utility room, baths and toilets. Dumbwaiter service is provided to the ward direct from the kitchen.

The isolation ward, occupying a space at the end of the corridor, has its own bath, toilet and lavatory. In the vestibule to this ward there is a lavatory for the use of both nurses and doctors.

placed across the corridor from the bedrooms to minimize the noise reaching patients. The terraces on the rear are required under the Ohio State Law, but may be used by patients, if desired.

The nurses' station is located to have complete control of the floor. The utility rooms will have a large drying closet, blanket and solution warmer and specimen closet. Equipment consists of a pack sink, disposal sink, bedpan rack, two utensil sterilizers (one for bedpans), one instrument sterilizer, cabinet, marble shelf and table.

The service pantry on this floor will be equipped with work table, three-compartment refrigerator, porcelain kitchen sink, drink mixer, fruit juice extractor, cupboard, electric stove and dumbwaiter service to insure serving patients promptly.



MARIEMONT HOSPITAL  
MARIEMONT, OHIO

SECOND FLOOR PLAN

In the removal of a contagious case, direct access is had to the outside through the stairhall.

The ground floor is reached either by elevator or by the two sets of stairs leading down from the first floor. This floor houses the laundry, machine rooms, boiler room, kitchens, grocery storage, dining rooms, mortuary, pharmacy, linen and sewing room, and out-patient department. The laundry, machine rooms and boiler room are not within the hospital walls proper, but are in the space which extends beyond the walls, under the service yard. The main kitchen on this floor will be operated under the "central tray service."

The second floor is given up entirely to special private and private rooms with two seven-bed wards for men and women respectively. All bedrooms and wards on this floor have direct access to the large porch, excepting the special private rooms, at the ends of the corridors, which are provided with individual balconies. All utilities are

Two of the special private rooms will have a common bath which can be cut off from the adjoining room by the latching of a door. In addition to the bath, each of the two center rooms will have its own water closet equipped for the emptying of bedpans. All private rooms throughout are provided with lavatories, radio head 'phones, outlet for telephone jack, electric fan, bedside light, "convenience" outlet for examination light or electric warming pad, and ceiling light. The lighting of bedrooms will be by a double operated ceiling outlet, a bright light for general illumination and a low candle power light to give a "moonlight" glow in the room when the patient is sleeping, yet providing sufficient light in the room for a nurse to move around. All doors leading from corridors to bedrooms are three feet, nine inches wide; in addition to the room door, there will be provided a "dwarf" door with panel sections filled with washable draperies.





## HOSPITALIZATION OF PNEUMONIA CASES\*

## Criticisms of the Recommendations of the Chicago Pneumonia Commission

By W. L. Moss, M.D., Assistant Professor of Bacteriology and Immunology,  
Harvard University Medical School

IT IS not surprising that recommendations, the adoption of which would increase the already soaring "per patient, per day" hospital cost and impose additional burdens on the nursing staff, should be a matter of grave concern to hospital administrators, especially when they emanate from men who occupy such high positions in the field of public health as do the members of the Chicago Pneumonia Commission.

The following discussion of the subject is submitted in response to a request from Colonel Frederic A. Washburn, director, Massachusetts General Hospital, who with a few other prominent hospital administrators, was called on by the editor of THE MODERN HOSPITAL, for an expression of opinion as to the advisability of adopting, in the absence of epidemic conditions, such stringent regulations as are contained in the commission's recommendations.

In his article Dr. Pierce has given an excellent analysis of the factors that contribute to make the mortality rate higher among hospital cases than among cases treated at home. It is to be noted that, with a single exception, these factors are in no way chargeable against the hospital, but are due to selective processes that result in the cases with least chance of recovery being sent to hospitals. To the several factors enumerated by the author as explaining the higher mortality among hospital cases may be added another that probably accounts for a considerable percentage of the increase, namely, the fact that critically ill patients are frequently transferred to a hospital shortly before death.

Pneumonia cases stand transportation very badly. Just what it is about transportation that

has such a deleterious effect on a pneumonia patient has not been satisfactorily explained, but the observation is sufficiently well established to demand the utmost care in transporting a case even a short distance, and every precaution should be taken to avoid exposure to cold, fatigue, or any form of strain. The author's observation of 70 per cent case mortality of all cases of non-residents,

brought into the city and hospitalized, is correctly explained by him, we think, as in large part a measure of the damage done to pneumonia patients by being moved and exposed.

During the influenza epidemic in 1918, I collected some statistics among the American troops in Base Section No. 2, A. E. F., which, while not entirely parallel to the above, afford striking evidence of the danger of transporting influenza as well as pneumonia patients. The

figures given are incomplete, as I have not all the data at hand. Of the cases reported here about one-fifth were treated in base hospitals and four-fifths in camp hospitals. Notwithstanding this disproportion in numbers, the base hospital series is probably large enough to yield percentages that are representative. The facilities for caring for patients, especially the nursing facilities, were much better in the base hospitals than in the camp hospitals, and yet the incidence of pneumonia and the mortality in the two groups of cases was approximately as shown in the table on the following page.

The following figures show that the development of pneumonia was nearly three times as frequent among the cases treated in base hospitals as in those treated in camp hospitals. In both series the mortality was confined to the cases that developed pneumonia, but this mortality was 41 per cent in the base hospitals, as compared to 31 per cent in camp hospitals; or if we compare the mor-

## A Subject for Debate

UNTIL further epidemiological studies have been made, it is difficult to formulate an ideal set of precautions for preventing the spread of pneumonia. There must always be a nice adjustment of the theoretically ideal and the practically attainable, and in suggesting a set of rules or in criticizing the recommendations of the Chicago Pneumonia Commission in regard to the hospitalization and institutional care of patients suffering from acute respiratory diseases, there must be debatable points about which there can be only an expression of individual opinion.

\*Hospitalization of Pneumonia Cases: Chicago Pneumonia Commission. Report No. 1, by C. C. Pierce, M.D., Senior Surgeon, U. S. Public Health Service Director, District No. 3, Chicago.—THE MODERN HOSPITAL, December, 1925.



tality in the total cases of influenza, we find it was nearly four times as great in base hospitals as in camp hospitals.

It is noteworthy that in the camp hospital series the cases were treated in the camp where they arose, while the great majority of the cases included in the base hospital series originated at a more or less distant point and were evacuated to

before the days of modern bacteriology. Furthermore, have we any proof or even any evidence suggesting that physicians and other attendants carry the infection of pneumonia to patients?

There are very marked differences in the ease with which different infections spread from individual to individual, and the factors influencing this are many. Important among these factors

	Total Cases Influenza	Influenza Plus Pneumonia	Percentage of Influenza Developing Pneumonia	Number Fatal Cases	Percentage Mortality in Pneumonia	Percentage Mortality Total Cases of Influenza
Base Hospitals..	1,607	319	19.9	132	41.4	8.2
Camp Hospitals..	8,348	567	6.8	176	31.0	2.1

the base hospital. The patients thus evacuated were not selected on a basis of severity. As a matter of fact, the admissions to base hospitals were made up, for the most part, from camps in which the hospital facilities were inadequate or absent, so that when the sudden increase in morbidity came as a result of the influenza epidemic, practically all the patients from these camps were evacuated to base hospitals.

From a careful study of the factors that might account for the higher mortality in the base hospitals the sole factor seemed to be the deleterious influence of transportation on these cases.

In his article on "Hospitalization of Pneumonia Cases" the author quotes Rosenau as follows: "If pneumonia were a new disease, it would be regarded as 'contagious,' and its spread would be guarded by isolation," and gives the following quotation from Vaughan: "If every physician, and other attendants of the sick, exercised well known precautions, and did not carry infection from one patient to another or permit such infection to be carried, the mortality from pneumonia would be greatly reduced."

To question the necessity for or practicability of maintaining the highest standards for the control of disease, or the most rigid precautions to prevent its spread, which may be recommended by such well known authors as are here quoted is to run the risk of being misunderstood. From the economic standpoint, however, there are practical limitations to the precautions that may be taken, and if we attempt to exceed these it is likely that the results will be unsatisfactory.

Of course we recognize the communicability of pneumonia, but is the facility with which it is communicated from one individual to another so great as to place it in the category of "contagious" diseases? I am assuming that the author, by the use of his quotation marks, intends to attach the significance to the word "contagious" that existed

are the accessibility of the portals of entry, the channels through which the infectious material leaves the body of patients and the viability of the virus outside the body. The frailty of the *treponema pallidum* outside the host is so great that a reasonable safeguarding of the portal of entry would reduce the incidence of infection with this organism to a minimum. In the case of tetanus, the resistance of the organism outside the body, its widespread distribution in nature and the fact that traumata of one sort or another which penetrate the integument are of almost daily occurrence, make surgical antisepsis and prophylactic serum therapy our chief weapons in combating this disease.

Tetanus is a communicable disease, but would hardly be classed as contagious, and for it to spread from one patient to another in a hospital, or to be carried by a physician or attendant from one patient to another would be evidence of the grossest breach of technique.

In addition to the factors mentioned above which influence the transmission of disease, are the very important and difficult to analyze factors of virulence of the infecting agent and resistance or susceptibility of the individual.

In the case of some diseases these factors are fairly well understood. For example, diphtheria bacilli are divided into virulent and avirulent strains, and it is generally accepted that a virulent strain may not become avirulent, and that an avirulent strain may not acquire virulence.\* Moreover, while there are degrees of virulence among the virulent strains, the variation is rela-

\*From time to time authors appear who claim to have converted a virulent into a non-virulent diphtheria bacillus or vice versa. The procedures for accomplishing this have varied all the way from the thoroughly orthodox methods of cultivating, on unfavorable media, at temperatures that deviate from the optimum, dessication, exposure to light, etc., for reducing; to passing through an English bullfinch for causing an avirulent strain to acquire virulence. Recently Crowell (Jour. Bact., 1926, XI, 21), working with pure strains, descended from a single cell, claims to have isolated in the sixth generation an avirulent culture from a parent strain that was fully virulent. If this observation is confirmed, we must admit the possibility of a virulent strain of diphtheria becoming avirulent.



tively slight, and all of them are sufficiently virulent to produce the characteristic lesions in susceptible persons. On the other hand, individuals are divided into those who are naturally immune to diphtheria and those who are susceptible. The Schick test differentiates between these two groups, and we know that the immunity of the one group depends upon the presence of circulating antitoxin in the blood and that the absence of antitoxin in the other group is responsible for its susceptibility.

Approximately 85 per cent of the population possess this natural immunity against diphtheria, and the degree of this immunity is adequate to protect against all ordinary, and probably even extraordinary exposure to the disease.

### Universal Susceptibility to Measles

Measles is in striking contrast to diphtheria. Infection follows exposure in an exceedingly high percentage of cases, if we exclude those who have been protected by a previous attack. This may be explained by assuming that natural susceptibility to measles is practically universal, and we may perhaps further assume that the infectious agent of measles maintains its virulence as long as it remains alive. The latter will have to remain an assumption until the virus of measles has been isolated and cultivated.

In pneumonia, we are confronted with a state of affairs differing quite widely from that which obtains in the two diseases just discussed. In the first place, pneumococci cannot be sharply divided into two groups, one virulent and the other avirulent; on the contrary, every gradation from those that are almost completely avirulent to those possessing a high degree of virulence are found. Moreover, a given strain of pneumococci may vary according to circumstances all the way from one end of the virulence scale to the other.

In the second place, individuals may not be sharply divided into a susceptible group and an immune group. There is no group of individuals whose relation to pneumonia corresponds to the position the Schick negative group occupies to diphtheria. There is no group whose security against pneumonia is as certain as that of cured measles patients against measles, and, fortunately, there is no group whose susceptibility to pneumonia is as great as either the group that is naturally susceptible to diphtheria or to measles.

Infection in pneumonia probably more than in any other disease depends on the relationship between virulence of the infecting organism and the resistance of the individual. Fortunately, the resistance of the normal, healthy individual to the pneumococcus is relatively high, and for infection

to take place there must coexist virulent pneumococci and a state of lowered resistance on the part of the individual.

I am not forgetting that in considering the hospitalization of pneumonia cases the author says the following: "the fact that pneumonia is not necessarily caused by one specific and definite organism does not, however, argue against its being a communicable disease." While in the preceding discussion of pneumonia I have considered only pneumococcus pneumonias, the statements made are almost if not quite equally applicable to pneumonias due to the streptococcus. These two organisms are responsible for the great majority of the pneumonias, and with the exception of pneumonic plague, we know of no form of pneumonia that is transmitted with such ease and regularity as to warrant classing it with measles, mumps, scarlet fever, small-pox, chicken-pox and the group of diseases that were formerly designated as contagious diseases.

Zinsser succinctly sums up his view on the subject in the following words: "The disease will not occur in an individual simply because he has received the virulent organisms directly from a case or a carrier, but, in addition to this, there must be coincident hygienic defects that temporarily depress his resistance. A temporary coincidence of two factors, therefore, transmission of the organisms and increased susceptibility, must occur. . . ."

### Possibility of Auto-Infection Noted

The only criticism of the above summary that I have to offer is that it seems to overemphasize the importance of recent transfer of organisms from a case or carrier and does not include the possibility of auto-infection with the individual's own pneumococci if he happens to be one of the large group who normally carry pneumococci in the mouth. It would be unfair to the author just quoted to assume that he did not recognize the possibility of lowered resistance resulting in auto-infection. In discussing the data obtained by the workers at the Rockefeller Hospital he says: "Following up this trail, workers at the Rockefeller Hospital have found that over 50 per cent of the mouth organisms found in normal human beings in and about New York City belong to the heterogeneous Type IV group, whereas, over 80 per cent of lobar pneumonias are due to Types I, II and III. The obvious inference from this reversed percentage is that lobar pneumonia is in most cases caused by organisms transmitted to the victim from an extraneous source, and that auto-infection with the patient's own mouth organisms cannot be regarded as a very common occurrence."

"It should not be concluded from this, however, that Type IV is unimportant as a causative agent in the disease."

The data referred to are given in the accompanying tables, which are quoted.

**Incidence of Types of Pneumococcus in Lobar Pneumonia**

Type of Pneumococcus	No. Cases	Incidence Per Cent
I .....	151	33.3
II .....	133	29.3
IIa .....	6	1.3
IIb .....	4	0.9
IIx .....	9	2.0
III .....	59	13.0
IV .....	92	20.3

**Distribution of Different Types of Pneumococcus in Mouths of Normal Persons\***

Type of Pneumococcus	No. Cases	Incidence Per Cent
I .....	1	0.8
II .....	0	0.0
IIa .....	1	0.8
IIb .....	7	5.8
IIx .....	13	11.6
III .....	34	28.1
IV .....	64	52.9
Pneumococcus present .....		116
Pneumococcus absent .....		181
		297

The difficulty in interpreting statistical data by any except professional statisticians (and sometimes they have been known to disagree) is notorious, but by calculating the percentages in the second table on a little different basis from that used by the authors, they seem to speak in favor of auto-infection with the patient's own mouth organism as of very common recurrence, at least in Type III and Type IV infections. This will be made clear if we calculate the percentage incidence of the various types of pneumococci found in the entire series of persons investigated, instead of calculating, as the authors have done, the percentage incidence of the various types of pneumococci among the individuals who were found to harbor the organisms in the mouth. Among the 300 persons studied, 64, or 21 per cent, carried Type IV pneumococci, and 34, or 11 per cent, carried Type III pneumococci. Compare these percentages with the incidence of types of pneumococci found in lobar pneumonia, as set forth in the first table. Type IV pneumococci were responsible for the disease in 20.3 per cent, and Type III pneumococci in 13 per cent of the cases.

I maintain that for the purpose of interpreting the significance of the pneumococci found in the mouths of normal persons on the production of pneumonia the percentages should be calculated, not as the authors have calculated them, but as shown above, and that when so calculated the parallelism between the incidence of Types III

\*The minor inaccuracies in this table may be disregarded in the discussion that follows.

and IV pneumococci in the mouths of normal persons and of these same types in cases of lobar pneumonia speaks in favor of rather than against a causal relationship. The extension of this analysis to Types I and II pneumococci does not permit the corresponding types of pneumonia to be referred to auto-infection and in these cases we have to fall back on the theory of transmission of the pneumococci, but this fact does not invalidate the evidence as it applies to the other two types.

The length at which this point has been discussed seems justified by the important bearing it has in determining the factors on which the development of pneumonia depends. The recommendation of the Chicago Pneumonia Commission for the keeping of "systematic records on all known secondary cases of pneumonia that develop in homes and hospitals" and the study of the "type and virulence of the infecting organism," if carried out, would supply data of great value in determining the point that has just been discussed.

### Pneumonia Epidemics Rare

It is no longer a question of whether pneumonia is communicable or not, but a question of the degree of communicability or the facility with which it is transmitted from individual to individual. The fact that two conditions must occur coincidentally—virulent organisms and lowered body resistance—ordinarily prevents pneumonia from reaching epidemic proportions. For an epidemic to occur there must be a simultaneous depression of bodily resistance in large groups of people and a widespread dissemination of the infecting organism among these groups. When these conditions are met, pneumonia may become a highly "contagious" disease. Indeed, it may reach a degree of contagiousness that leaps over all barriers set for its control. Such epidemics, of course, are the ones associated with influenza. On a smaller scale, but analogous to the conditions that obtain during an epidemic of influenza, are those that prevail following measles, and scarlet fever, and perhaps to a still lesser degree following certain other conditions.

There are so many factors that have to be taken into consideration that it is difficult to lay down hard and fast rules to be followed at all times and under all conditions for the hospitalization of pneumonia. Regulations that might prove adequate to prevent the spread of pneumonia in ordinary times would be inadequate during epidemic periods. In the most ordinary times patients suffering with, or convalescent from, measles or scarlet fever should not be exposed to



patients with pneumonia, even if such exposure could be effected with impunity as far as the pneumonia patients were concerned. On the other hand, it is a common experience to see pneumonia patients treated in open wards with twenty or thirty patients suffering from a variety of diseases with no spread of the pneumonia, even where no more elaborate precautions are taken than those that would be taken routinely in the case of all patients in a well regulated hospital. This seems to indicate that the coincidence of the transmission of virulent pneumococci to persons whose resistance to pneumonia is lowered must be of comparatively rare occurrence, even among hospital patients.

### Dangers in Transportation of Patients

The higher mortality rate among pneumonia patients in hospitals has, I believe, been correctly explained and it in no way indicates that there is any circumstance in connection with the hospital treatment of the case that makes the chance of recovery less than it would be under average conditions in the home, except the danger to the patient of being moved after the disease has developed. That this is a real danger has been abundantly proved, but this fact does not seem to have led to any general adoption of measures to lessen this danger. The transportation of pneumonia patients should be accomplished with the least possible exposure of the body to general chilling, physical fatigue or disturbance of mental tranquility. The transit from the home bed to the hospital bed should be as direct as possible, with a minimum of detention and examination in the admitting room of the hospital. Warm food and stimulant should be administered, in case of need, as soon as the patient reaches the hospital, and there should be a minimum interval between the time the family physician and the home nurse cease to function and the house officer, and especially the hospital nurse, begin to function.

In advocating the hospitalization of pneumonia cases, the author states that "there are certain advantages, both to the patient and to the community, in having pneumonia cases treated in hospitals." I am quite in accord with this view, and to the summary of the advantages that the author gives would add that with the more constant observation in the hospital, complications, such as empyema, should be recognized earlier and more promptly treated.

It is exceedingly difficult to strike just the right balance between measures that are theoretically desirable and those that are practically attainable, and while the recommendations of the Chicago Pneumonia Commission are admirable, I feel that

during non-epidemic periods and until a stronger case can be made out against the carrier, or until we learn more of the routes by which the infection travels from one individual to another, these recommendations may be modified somewhat in the interest of practical attainment. To make my criticisms specific, the commission's first recommendation reads as follows: "(1) The visiting of persons suffering from pneumonia who are under treatment in hospitals or other similar institutions should be prohibited except in cases of actual emergency." Instead of prohibiting visiting, I think it possible and preferable to restrict it to a point where the danger of transmitting the disease will be very nearly nil and the natural desire of the patient and his family to see and keep in touch with each other will still be satisfied.

The second recommendation is: "(2) Cases of pneumonia should not be treated in a general ward of a hospital, except that, when no other adequate care of such cases is feasible they may be treated in cubicles in wards, with properly instructed attendants and special disinfecting facilities, including proper solutions, kept close at hand, and bedpan, dishes, thermometers, towels and hands are properly washed and disinfected, and the nose, throat and mouth discharges of the patient are destroyed." In ordinary, non-epidemic periods, in wards where the proper space between beds is maintained and where the nurses and attendants observe the rules of simple cleanliness that should obtain in any well regulated hospital, it is doubtful if any spread of pneumonia from one patient to another will occur. If during an emergency, or for any temporary reason, the proper spacing of beds cannot be maintained, the cubicle serves a useful purpose. Moreover, in wards for the treatment of some of the more readily communicable diseases, cubicles are to be recommended.

### Simple Precautions Effective

Among the better hospitals, the policy should be, and I think is, to install facilities and adopt as routine a technique that safely disposes of secretions, discharges and dejecta from all patients, regardless of the disease from which they are suffering. The sterilization of bedpans is becoming routine in many hospitals. Experiments conducted at Saranac Lake, N. Y., several years ago indicate that careful washing of dishes, knives, forks and spoons is sufficient to prevent the spread of tuberculosis through the agency of these articles. Scalding or actual sterilization as a routine may be added to thorough washing, and is an additional safeguard, besides saving the time and expense of wiping them. In no hospital should



the towels, bedding or clothing of one patient come in contact with another, and the precautions which the nurses and other attendants in a hospital are taught to take for their own protection should prevent their transferring disease from patient to patient.

If the commission's second recommendation is adopted, the third should also be adopted, and cases caused by different types of pneumococci or streptococci should not be exposed to each other.

The fourth recommendation of the commission is as follows: "(4) Cases of pneumonia under treatment in hospitals should not occupy beds within ten feet of or otherwise be in close contact with persons awaiting operation or recently operated upon; with persons hospitalized for heart disease; with persons having Bright's disease; rickets; various forms of contagious diseases that might be complicated by pneumonia; severe burns or injuries, or other conditions that lower the resistance to pneumonia."

#### What Autopsy Statistics Show

In this recommendation does the commission suggest that greater precautions are necessary than those contained in recommendations (1) and (2) in order to safeguard the classes of patients enumerated from exposure to pneumonia patients? This brings up a question of much interest and importance. In autopsy statistics perhaps "broncho-pneumonia" recurs with greater frequency among the anatomical diagnoses than any other, certainly in persons past middle life who suffer from any chronic disease a terminal broncho-pneumonia is the commonest immediate cause of death. Do these cases represent auto-infection or is the streptococcus or pneumococcus usually derived from "a case or carrier"? The great majority of autopsy statistics are made up of hospital cases. Are we to infer from this fact that terminal broncho-pneumonia is peculiarly a hospital disease, the infection being spread directly from patient to patient, or by means of nurses and other attendants? Is it possible that in terminal broncho-pneumonia we have a condition analogous to that which formerly existed in the lying-in hospitals in regard to puerperal sepsis? God forbid, but the question merits study.

If the commission's preceding recommendations are adopted, (6) and (7) should also be adopted for the sake of consistency.

The eighth recommendation: "(8) Patients with acute coryza, sore throat or bronchitis should not be operated upon under general anesthesia except in cases of emergency; nor should persons so affected participate in operations. After each operation and before the next operation the anes-

thetic face mask, etc., should be properly sterilized." This recommendation is sound and is generally in effect except, perhaps, the injunction "nor should persons so affected participate in operations."

The commission's ninth and last recommendation is: "(9) Whenever pneumonia develops to an exceptional degree in any hospital or institution, all persons in contact with the patients should be cultured for pneumococci and nearly related organisms, and when such organisms are found they should be 'typed.'" This recommendation is excellent as far as it goes, but it does not tell us what to do to prevent the development of pneumonia to an exceptional degree after all contacts have been cultured and the pneumococci present have been typed.

#### When Special Precautions Are Needed

To conclude, it is the personal opinion of the writer that during ordinary times in well regulated hospitals pneumonia rarely spreads from one patient to another; that the danger of such spread does not necessitate the special and somewhat elaborate precautions recommended by the commission; that the increased expense to the hospital and burden on the nurses and other hospital personnel imposed by the special precautions recommended outweigh the possible good that they might accomplish; that it is not necessary to adopt special precautions to prevent the exposure of measles, scarlet fever and other very readily communicable diseases to pneumonia patients, as there are obligatory regulations to isolate these patients from not only pneumonia patients but all others; that instead of multiplying special precautions to prevent the spread of particular diseases, the effort of hospital administrators should be to adopt a uniform routine that will be adequate to prevent the spread of infection from one patient to another through the agency of secretions, discharges, dejecta, clothing, linen, thermometers, bedpans, urinals, dishes, or through the agency of hospital attendants; that a uniform technique even of such high standard will not cost the hospital more or impose any greater burden on the nursing staff and other hospital personnel than will the multiplication of special precautions; that the adoption of this policy will reduce the number of diseases in which special precautions are required, to a minimum that will probably not much exceed those diseases customarily handled in special hospitals; that under abnormal conditions, notably during a widespread epidemic of influenza, pneumonia may become a highly "contagious" disease, and at such time the most rigid precautions should be taken to prevent its spread.

## STUDIES ON HOSPITAL PROCEDURES

[This department, with this issue, appears under a slightly changed heading. For the somewhat chatty "Notes on Administrative Procedures," has been substituted the more thoughtful title, "Studies on Hospital Procedures."

It is the object of this department not to presume to detail the only methods of efficiently administering the hospital business, but to set down, from month to month, some of the more or less generally accepted professional and administrative procedures, as gleaned from the opinions of successful hospital executives throughout the field. To this end, beginning in this issue and continuing in future issues of *THE MODERN HOSPITAL*, will appear a discussion of practical methods, in so far as the major hospital departments are concerned. It appears wise to first review, without any attempt at completeness, some of the time-tried, basic laws of organization, affecting hospital administration.—Editor.]

### ADMINISTRATION OF THE HOSPITAL AS A UNIT

**C**ENTRALIZATION of authority is necessary. In most hospitals this authority is vested in a superintendent, who is answerable to the board of trustees, whose authority he administers or executes. The rules of the hospital, approved, if not actually formulated by the board of trustees, are given to the superintendent, who becomes the enforcement officer. This authority is then delegated, by the superintendent, to the department heads, such as the chief resident physician, the superintendent of nurses, the dietitian, the chief engineer, who, in turn, interpret and enforce the rules of the governing board, in so far as their divisions are concerned. These department heads, therefore, receive authority from the superintendent, to require obedience to hospital regulations on the part of their subordinates.

It is often found to be good administration to allow department heads to formulate rules for governing their own departments. Indeed, rules that are suggested by intelligent subordinates, and later approved by the superintendent and board of trustees, often are best observed, because of a pride in doing well what they originally suggested.

Here enters something of the idea of self-government, which makes a democracy the government of choice.

With centralization of authority usually goes some degree of decentralization. When decentralization takes place, the superintendent, after placing competent heads over each hospital department, does not require the minute report to him of minor happenings. He allows these heads to engage and discharge help, with his approval, and requires, in a general way, consultation with him by the department heads on matters of policy only. By this plan every ounce of constructive and executive ability is secured from each one in authority, who is thus placed on his mettle. Discouragement and irritation over what may seem to be unsympathetic criticism on the part of the executive are thus avoided.

This system of administration has many advocates, and consists, essentially, of outlining a problem, and then allowing the department head an opportunity to work out his own salvation, until he proves unable to do so. Of course, the wise administrator does not so decentralize that he is not generally cognizant of the major details of every department; but the chief argument in favor of the latter scheme is, that the head of the hospital is enabled to give more time and thought to developing the larger interests of his institution, such as directing drives for endowment, strengthening and clarifying the place of the hospital in the community health program, and acquainting himself with the newest developments in the hospital field.

Whichever plan is adopted, or as is usually the case (dependent on the efficiency of department heads), if a modification or combination of both is pursued, the superintendent's morning chat with department supervisors is most efficacious in strengthening hospital morale. Many successful executives set aside definite hours for these conferences, as is illustrated by the following suggestive schedule:

- 8:30 to 9:00 a. m.: Reading of the morning mail, emergency dictation.
- 9:00 to 9:15 a. m.: Conference with the dietitian.
- 9:15 to 9:30 a. m.: Conference with the superintendent of nurses.
- 9:30 to 9:45 a. m.: Conference with the chief engineer or foreman of maintenance.
- 9:45 to 10:00 a. m.: Conference with the medical representative (chief resident physician or senior house officer).



It is usually thought wise to hold these conferences separately, because less time off duty is lost by each person, and also because the dietitian and the chief engineer, for example, have but few common problems to present to the superintendent. Many administrators are of the opinion that by daily meeting the members of their cabinet for a few moments they keep the interest of their hospital workers at concert pitch, and thus prevent stagnation in any department. These morning conferences may not be held daily, and the schedule for conferences may be so altered that each department head will come to the superintendent's office every other day, or even every third day.

As a further means of developing a healthy *esprit de corps*, a monthly group conference—at which all department heads are in attendance—has been found helpful. There is a mutual stimulus to be gained from frequent, personal contact between the superintendent and his co-workers, which is not derived from an interchange of type-written orders and formal reports. Discouragement, arising from the delayed arrival of supplies, of a supposed hypercritical attitude on a physician's part, often disappears when the whole situation is discussed with the hospital superintendent.

### HIRING AND DISCHARGING OF EMPLOYEES

In some of the country's best hospitals, there is an employment director who engages all help, especially such employees as orderlies, maids, charwomen and waitresses. The immediate superior of these persons, when engaged, is responsible for their conduct and the efficiency of their work. In the case of the orderlies and ward maids, this person is usually a head nurse, and in the other instances it is most frequently the

housekeeper or head of the dietary department.

This officer is not necessary in the small hospital. And it often appears the best plan for the newly engaged employee to feel that he owes his appointment, and hence his loyalty, to his immediate superior. Here again, the principle of decentralization is effective in producing good discipline, and a heightened and steady hospital morale.

When dissatisfaction with the work of these employees exists, or when they are absent from work because of illness, or for any other reason, a slip, such as is represented below, is often used to acquaint the pay roll clerk in the superintendent's office with this fact. The use of some such form appears wise to many executives, because delay in reporting the absence of employees, either from sickness or for some other reason, results in no little financial loss to the institution in the course of a year. The actual discharge of the employee, if such is necessary, comes only when the superintendent approves the recommendation of his subordinate, which is the usual procedure.

This system is useful in listing reasons for discharge, so that inefficient or other undesirable employees may be prevented from repeating their offenses in the same hospital at some later date. A card index, containing in a few words the records of minor hospital employees, can thus be easily compiled, and is found useful by many superintendents. These records may also be of use in supplying superintendents of other hospitals with information concerning applicants for positions.

### REPORTS OF ACCIDENTS AND INJURIES

In any system of hospital administration extreme care is always taken to prevent any accident, such as a hot-water bottle burn, an injury from falling out of bed, a bruise or an abrasion

#### DUTY SHEET

MR. JOHN DOE,  
Superintendent.

.....1926

.....reported  
.....failed to report } for duty  
.....reported unfit }

on.....Ward.....Department..... } A. M.  
 } P. M.

.....1926.

Work .. } Satisfactory  
 } Unsatisfactory

(Signed) .....  
Head Nurse.

THE GREATHEART HOSPITAL  
TOONERVILLE  
ACCIDENT AND INJURY SLIP

MR. JOHN DOE,  
Superintendent.

At.....A.M. I discovered that  
P.M.

Name ..... Department .....

had.....  
[ abrasions  
contusions  
lacerations  
bed sores ]

on.....  
injured at.....A.M. ....1926, in the following manner  
P.M.

Witness .....  
who can verify the above statements. This patient was seen by Dr. ....  
..... minutes after the injury took place.  
(Signed)..... Ward Nurse

Inspected by me at .....P.M. .... 1926  
A.M.  
(Signed)..... Head Nurse.

suicide, on the part of the patient, a report is usually made by phone, a more complete report, giving the circumstances and the names of witnesses, being later submitted.

In the case of accidents, in which the institutional ambulance figures, and which might give rise to later legal complications, a full report to the superintendent is of the greatest moment. Ambulance drivers and interns are usually instructed as to the necessity for an accurate notation of the time of day, the condition

from carelessness in handling an unconscious patient, or the development of a bed sore from the use of an ordinary hair or fiber mattress, when an air bed might have proved a preventive.

Some hospitals employ a special form upon which such accidents are promptly reported to the superintendent's office. The use of such forms is conducive to the prompt reporting of these conditions, and they are easily filed for future reference.

A copy of a form, which may be used for this purpose, is given above.

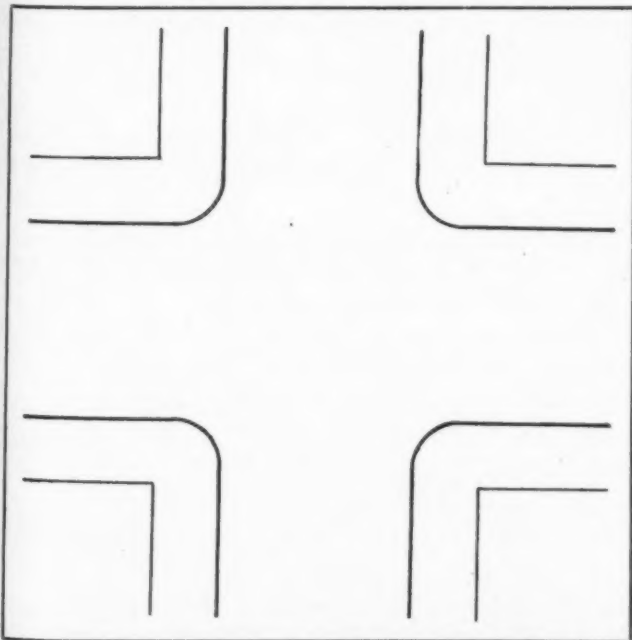
In emergencies, such as would be represented by a successful or an unsuccessful attempt at

of the pavement, the speed of the colliding vehicles, or the position and direction of motion of the pedestrian who was injured. A diagrammatic form, such as is shown in the accompanying illustration, is often the basis of a successful defense of the driver, even though the suit is not aimed at the institution proper. To secure a full list of witnesses to the accident is important.

THE GREATHEART HOSPITAL,  
Toonerville

TRAFFIC ACCIDENT AND PROPERTY  
DAMAGE REPORT

1. Name of injured.....
2. Home address.....
3. Name of owner.....
4. Auto License No.....
5. Home or business address.....
6. Place of accident.....
7. Date of accident.....
8. Time of accident.....
9. Extent of damage.....
10. Extent of injury.....
11. Condition of roadway.....
12. Cause of accident (in detail).....
13. Statement made by injured as to cause of accident.....
14. Name of driver.... Home address....
15. Reported by whom.....
16. Names and addresses of witnesses... ..
17. Make sketch.....



This diagram goes below item 17 in the next column.





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## IN HOC SIGNO VINCES

THE splendid response from hospital men and women everywhere to the suggestion that an insignia be sought that will represent, in a composite way, the service of the hospital to its community, is gratifying to the editorial staff of this magazine. It is a contradiction of the too often repeated statement that hospital executives are not progressive; that they cling too long to the old, and look with suspicion on the new.

When the opinions (printed in both this and in the April issue) are studied, of those either actively interested or actually engaged in hospital work, two common beliefs are unmistakable. First, that all are of one mind as to the desirability of such a symbol, and, second, that so many are the angles of the hospital's work, so varied are its curative and preventive activities, that to represent these adequately by a sign of sufficient simplicity to be practicable and usable, will be, indeed, a difficult task.

But this latter fact should only add zest to the search. If the spirit of the hospital is to be militant and not passive; if it is to advance and never retreat in the war on disease, is it not appropriate that, like the warriors of all ages, its ensign should be in the van?

It is said that many centuries ago, the soldiers of Constantine, the Great, as they went forth to do battle with the legions of Maxentius, the Pretender, saw traced in the skies a flaming cross, under which was inscribed in letters of fire these words: "In Hoc Signo Vinctes." Everywhere in the field is the question being asked: What shall be the sign under which the hospital of today shall go forth to conquer disease? Physicians, in untold numbers, have followed their caduceus, with its wings of the herald, and its serpents of wisdom, to the doors of countless hospitals, and there have taught and have been taught the science and the art of healing the sick.

But the hospital is not only a place of science, but a hostel, where warmth and hospitality await the stranger. It is a home. It is a school. It is a laboratory, where causes and cures are sought. It is a great business, where costs are carefully studied, and efficiency in management is of great importance. It is a business with a priceless chief product, but likewise an undertaking that is rarely operated at a profit.

The editors of THE MODERN HOSPITAL are more than confident that from some individual source, or as a composite of many suggestions, will come a symbol that will appear to all to be generally adequate and appropriate for the purpose of representing the hospital.

### WHEREIN LIES COURAGE?

IN A southern hospital a number of patients were asked what quality they admired most in nurses. Their answer is interesting and illuminating. All of these patients were men. Their ages varied from twenty to fifty years. None of them had achieved any remarkable success in life and for the most part, they were simple, wholesome human beings who had seen the seamy side of things and who appreciated the comfort of a hospital.

The quality that almost all of them admired in nurses was their courage. Rather an unexpected answer, this, but one that shows a keen insight and deep appreciation of what goes into the making of a nurse's life. A real nurse does possess courage and she has demonstrated this times without number in the arena of war, pestilence, famine and disaster. It requires a very purposeful courage to attack the many disagreeable tasks that enter into the nurse's working day, and the ability to control the emotions takes on the attributes of courage.

Every war has demonstrated that physical courage is one of the commonest attributes of mankind. To a considerable extent this grows out of pride, which will not allow a person to betray his fear to his fellows. The nurse possesses pride and physical courage but she also should, and usually does, exemplify that rarer virtue of moral, or to use a better and more accurate word, ethical courage. Without labeling it as such, this is what those patients meant when they expressed their admiration of the nurse's courage. It takes character which, after all, is ethical courage, to meet the daily grind of ministering to the sick, to be accurate and loyal, to be cooperative and at the same time individually resourceful. Yes, among the many superb qualities possessed by nurses, courage leads all the rest.

### A LASTING MONUMENT

IN A recent issue of the *Survey*, Dr. Richard Cabot discusses in an interesting manner the ethics of the physician of today. He describes the delightful relationship that often exists between the visiting physician and his intern—a relation of preceptor to pupil—of professional and personal friendship. He depicts the effect on the character of the younger man, which comes from contact with his kindly, dignified and learned chief.

Many eminent physicians today look back thankfully over the years to a doctor of the old school, from whom correct ideas of ethics, of

etiquette, and of medical morals were learned in days gone by.

The hospital superintendent has just this opportunity of perpetuating himself. It may be a young assistant, or any other member of his official family, who will "carry on" when he is finished. There is no finer or more lasting monument to the memory of a man than that engraved on the hearts and minds of his fellows. There is no surer way of doing good than to train others to "carry on" where and when we cannot. To perpetuate the methods and the manner of the outstanding administrators of this day is one of the many arguments for the more general establishment of schools for the training of hospital executives.

### LOWERING STANDARDS TO REDUCE COSTS

RECENTLY in an attempt to give the people what they want a few hospitals have become agitated over the shortage of trained nurses and have declared themselves in favor of lowered standards for training schools. They have championed the cause of lowered standards as a remedy for the mounting costs of nursing service which public outbursts deem prohibitive.

A few institutions, otherwise modern, ascribe to the old idea that a maximum of character or morality and a minimum of education suffices to produce the best nurse, and accordingly keep their training school entrance requirements down to a grammar school education and an aptitude for hard physical labor. These hospitals would then put these entrants through two, instead of three, years of practical training and turn them out of the mill as soon as possible to serve the public at lowered costs.

It is these hospitals that view with suspicion the present tendency toward an enlarged curriculum, with more emphasis upon education and less upon experience gained in the performance of menial tasks. Even though it may appear that the pendulum is swinging to the other extreme in the movement for more education, it must not be overlooked that the welfare of the profession of nursing, the promotion of which is one of the functions of the hospital, is at stake. A few hospitals cannot lower their training school standards without lowering the standards of the profession. Such action inevitably tends to put nursing on a lower plane by attracting less desirable candidates and by encouraging the "get-through-quick" type of training which, in the end, means inefficiency.

Admitting that the costs of nursing service, re-



ardless of their causes, have mounted almost to the prohibitory point and that the problem should be faced squarely, the remedy does not lie with the dissociated efforts of one or two institutions or even of those of one or several districts. The problem has to be solved by the united efforts of all those organizations and institutions that have nursing interests at heart.

Whatever may be the outcome of the work of the Committee for the Grading of Nurse Training Schools, it will be the product of those who are best qualified to handle the problem impartially in its broader aspects, and we may reasonably expect their decisions to be those that will prove best for all.

### TALKING IT OVER

OUR progressive neighbors in the South Pacific—Australia and New Zealand—are making long strides in bringing their hospitals up to higher standards, and in common with the other English speaking countries they are fostering the community hospital idea as the basic philosophy of the public hospital.

In Australia the public hospitals giving general service are governed by private, incorporated bodies, and the maintenance is by both private subscription and state government subsidy, there being no assistance from the municipal tax fund, while in New Zealand both the state and municipality participate. By and large, the average standard of these hospitals is higher than the standard of those hospitals in the United States that are controlled by states and municipalities.

\* \* \*

IN THE near future we hope to have a close-up view of Australia and New Zealand hospital service from Dr. M. T. MacEachern, "the apostle of standardization," who is now inspecting the institutions at the invitation of the governments of those countries. That the progress of our own country is being closely observed is apparent from the following excerpt from a recent letter from Dr. MacEachern: "It was a most pleasing feature to me to see how much THE MODERN HOSPITAL is being used in Australia, the high esteem in which it is held and the fine influence it is having in improving hospital methods. Strange to relate they all knew me through this splendid magazine and it has inspired me to work harder for it. America may well be proud of this fine publication."

\* \* \*

MAY is the month of commencements in many of our schools for nurses. How anxiously for three long years have the members of the Class of 1926 been looking toward this month! It is the time when seasoned hospital superintendents, and directresses of nurses gladly, although sometimes rheumatically, climb down from their dignified high places, and bend their efforts toward honoring the members of their graduating classes. And honor them they should, for those of us who have observed the metamorphosis of the hesitating, uncertain and untrained probationer, with her debonair outlook on life and her duty to others, into the purposeful, skilled, and resourceful graduate nurse, are continually filled with wonder at the change.

What is the ferment that has worked these changes?

What has transformed the immature high school girl of but yesterday into the more thoughtful and responsible woman of the graduating class? The reasons may be many, but has not the most potent factor been that to them has come, for the first time, a knowledge of a great need; a taste of the joy of getting by giving, and a glimpse of the secrets of life, and the menace of death? Is there not just a suggestion of the cocoon and the butterfly in the young nurse's life? Here comes the graduating class—hat's off!

\* \* \*

CROSS infections are nightmares in the life of the superintendent of a contagious disease hospital. To have a patient suffering with chickenpox develop measles is bad enough, but a complaint made by a man of not too temperate habits, who was recently discharged from one of our large municipal hospitals, is unique. Here it is:

"Dere Sir,

I want damadges. I went to your hospitle with the D.T.s, and came out with the T.B.s.

Yours truly,

\_\_\_\_\_"

\* \* \*

THE "good enough" spirit is the bane of hospital administration. "Oh, I guess that's good enough," "Well, that will do" are phrases that are constantly preventing high class performance. As Americans, we have placed too great a premium on speed and as a result have developed a sort of slapdash spirit which is satisfied with less than thoroughness and accuracy. If a piece of work is not perfectly performed, we are apt to say "Well, it is good enough to get by with" or "let it go at that." As a corollary to our worship of speed is the adoration of quantity as opposed to quality. Of course it is trite to say that how much is done is less important than how well it is done. Manufacturers are learning that wherever thorough accuracy has been used in production markets have been opened and retained. Hospital executives are, so to speak, hospital administrative engineers and they should perform their various functions with the scrupulous thoroughness and accuracy that is employed in other branches of engineering. The sanctity of their responsibility to the sick demands of them that there be no careless "good enough" spirit in the performance of their work. A hospital is no better than the people who run it and the repudiation of duty in any of its minutiae is ruinous to that reputation for solidity and dependability that hospitals should exemplify. In other words, they should be animated not by the spirit of "good enough," but by that of "how good."

\* \* \*

MOST hospital administrators give at least lip service to the principle that they bear an intimate relation to the general health of the community, but this is a matter that demands extension if the hospital field is genuinely to promote the public health.

It is therefore important that each of us should ask himself if he is doing his full duty toward the accomplishment of this ideal. Is every patient taught the necessity for the maintenance of his mouth in a healthy condition? Do we try to spread the gospel of healthful eating? Do we preach the necessity for cleanly, well ventilated homes? Do we endeavor to indoctrinate patients with the idea that the community must maintain an adequate health service? Do we ever say anything to our clientele about the relationship between insects and disease, the necessity for periodical health examinations and the many other means of lengthening the life span?

Every patient is a potential distributor of the health ideal. Vaccination, the prophylaxis of typhoid fever, diphtheria and scarlet fever can all be taught. This is a great field and there is an enormous work to be done in it.

\* \* \*

DID you ever stop to think that every phone call that comes to your switchboard is in reality a visitor to your hospital? If a cheery "good morning" comes over the wire, the visitor is pleasantly impressed, and mentally notes the probable cheer and sunlight that must enter the wards of such an institution. If a brusque, "Well," or even an irritated, "Hello" is the salutation, how different is the impression. Yes, next to having cordiality and kindness meet the patient at the front door, is to send these priceless qualities out over the telephone wire to those who thus visit your hospital from a distance.

\* \* \*

IN ANOTHER part of this issue appears an article by Dr. E. H. Lewinski-Corwin, entitled "Measurement of Social Progress," that has a distinct appeal to all who are interested in health and hospital work. Dr. Corwin points out the need for some sort of a measure for illness, which he has termed "pathometry." He states: "By the aid of pathometry we shall be able to figure the sickness rate in the several occupations and to establish prevailing norms."

\* \* \*

THE hospital vocabulary is a thing of wonderment to the uninitiated. The surgeon orders a "stat;" the drug is prescribed P.r.n., t.i.n., or q.i.d., by hypo; and the nurse has P. M. hours today. The intern has his service on Gyn or Mat, and the ambulance physician is on second call to "ride the buggy." Is it any wonder that when the poor patient hears this jargon, and much more, he thinks some one is talking about him?

\* \* \*

HEALTH, enthusiasm, intelligence, faith, loyalty—these five are essential to success. Possessing them failure is impossible; without them mediocrity or complete disaster is certain. Health, the quality of haleness, wholeness, holyness, is, etymologically, closely akin to heal. It is therefore peculiarly necessary that those who are engaged in the care and remediation of the sick shall maintain their physical and mental health at the highest level.

Enthusiasm comes from a Greek root meaning "possessed by a god." It is the god-inspired quality of interest and devotion to the work in hand, lifting its possessor over obstacles and carrying him forward in the face of opposition. It makes of work a joy instead of a drudgery, constantly leading to better performance. It is the divine spark that kindles the torch of progress.

The derivation of intelligence shows that it means the ability to pick and choose between. It connotes a sense of relative values, a sense which, unfortunately, is woefully lacking in many people because while there are many who are learned or trained, real intelligence is not a common quality. Discernment, insight, common sense, thoroughness, all flow from it.

Faith, the settled, unswerving belief in the cause and oneself, the Jack which slays the ogre of worry, the sublimest of all the virtues, which transmutes the dross of individuality into the gold of character, is the cornerstone of success.

Loyalty, the higher law, the attribute of steadfastness in defeat and victory, the perpendicular virtue that must go up from subordinate and down from superior and that

binds the forces of individuals into an unbreakable whole is the fifth essential to successful performance. These five are capable of development and it is the duty of leader and led alike to strive daily for their acquisition.

\* \* \*

THERE is an old medical precept to the effect that the symptom is often far, far from the seat of the disease. A pain in the shoulder may mean trouble in the gall-bladder, or it may just mean rheumatism in that important joint. To treat a sick gall-bladder by rubbing the shoulder would not bring results.

Good food in the garbage can is a symptom that may mean many things. Now, a garbage can is not often a thing of beauty, but from its close inspection many truths may be gleaned. Too much bread or potatoes or rice therein may mean improper ordering, or serving, cooking or buying, each with its cause and remedy. Perhaps the visiting physician ordered "select diet," for fear that, nausea having subsided, his patient would be hungry before his next visit; or, perchance, the baker has delivered a poorly cooked product, or, possibly, the nurse has had a too generous impulse overpower her when serving. However, this is certain: the symptom demands, not treatment of the garbage can but of the source of the trouble, which may be several hospital blocks away.

\* \* \*

EVERYTHING depends upon the way in which life's work is approached. If every task is regarded as an opportunity to do better work, to acquire additional knowledge and skill; if it is approached with enthusiasm; if it is made the thing which one most wants to do, the reward will be a great happiness and peace of mind; the art of accomplishment will be acquired and the next problem will be easier of solution.

Contentment and happiness are mental states that depend upon an inward grace rather than upon external stimuli. If we take a discontented attitude toward life, we shall get very little out of it except heartaches. When you "boost," you raise your own morale and consequently that of those about you. "Boosting" is a moral tonic just as "knocking" is a depressant. When an engine knocks, it is a sign that something is wrong with it. When you knock, something is wrong with you.

\* \* \*

THOSE who have graduated from a professional or technical college are ordinarily held to be educated people. As a matter of fact they are not necessarily so. Many persons are splendid technicians but cannot in any sense of the word be classed as educated. Training means the development of skill and dexterity in a given occupation; education means that the mind has been educated, that is, led out. Education supplies a knowledge of the mistakes and achievements of the past and stimulates the power of reasoning from the known to the unknown. It cultivates a perception of the relative values of the things of life and promotes a love and understanding of those that are beautiful, sound and true in character, mind and environment.

The worker in the hospital field, if he is to accomplish the highest usefulness, cannot afford to be merely trained. He must broaden his intellect and extend his mental horizon by never ceasing self-education. He must, to be sure, constantly strive for improvement in his professional technique but above and beyond this he must daily seek advancement along cultural lines, following the paths that our ancestors, with a fine sense of the fitness of things, called the humanities.



## NEWS OF THE MONTH

### ILLINOIS ASSOCIATION PLANS FULL TWO-DAY PROGRAM

A two-day program of study of hospital problems is being planned for the third annual meeting of the Hospital Association of the State of Illinois to be held at the Hotel Sherman, Chicago, May 7 and 8.

The program May 7, will be taken up with the reports of officers, a paper on nursing by Maude Essig, superintendent of nurses, Brokaw Hospital, Normal; one on problems relating to hospital additions, by E. I. Erickson, superintendent, Augustana Hospital, Chicago, and one on methods of arousing interest in nursing and developing a school spirit, by Nan H. Ewing, principal, school of nursing, Ravenswood Hospital, Chicago. In addition to the papers there will be a round table discussion conducted by E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, and talks by representatives of the American Hospital Association, the American Medical Association and the American College of Surgeons.

Throughout the program a wide variety of subjects will be covered in the papers and discussions. Some of those to be touched upon are the hospital hostess, food service in small hospitals, cooperation from the community chest in caring for free patients, ways of winning financial support, National Hospital Day, the municipal tuberculosis sanatorium and provision of facilities for contagious disease.

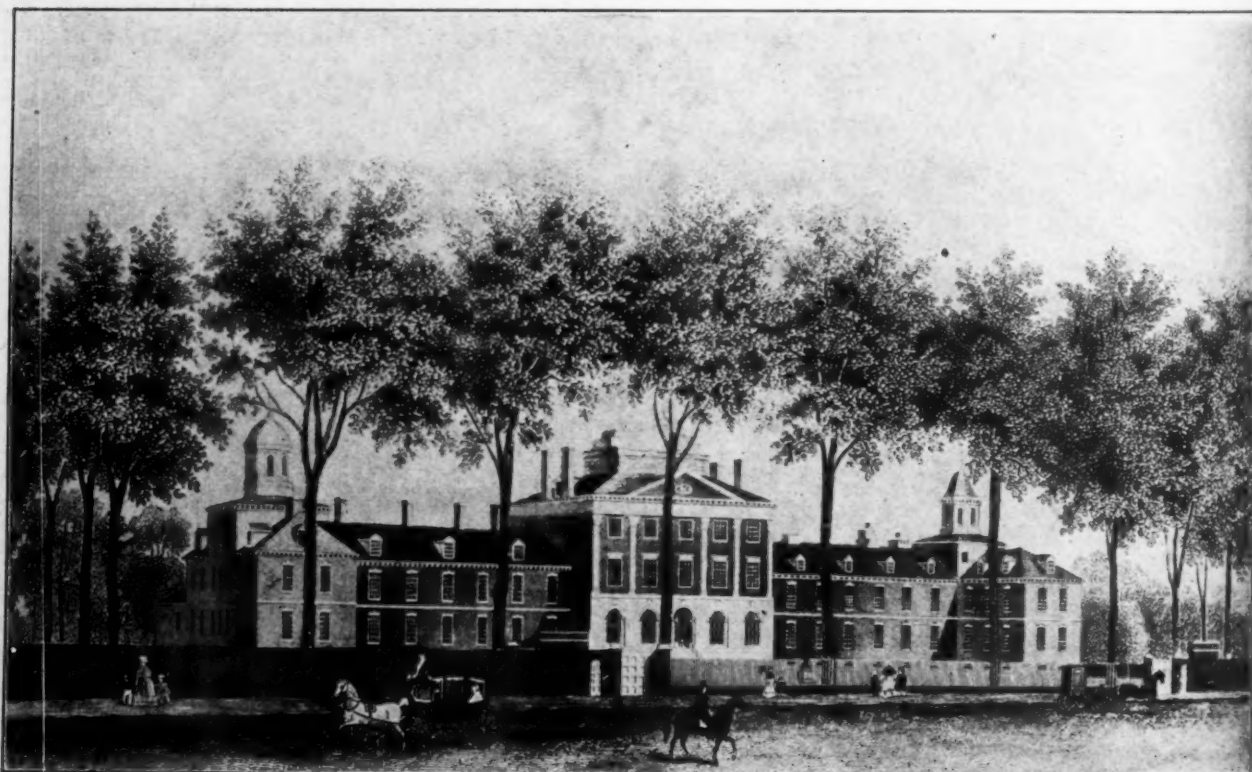
Special features of the convention will be the get to-

gether luncheon, Friday noon, the annual dinner, Friday evening and the musical program and tea to be given at the new Palmer House, Saturday afternoon, under the auspices of the Women's Auxiliary Board of the Ravenswood Hospital, Chicago. Preceding the tea, visits will be made to some of Chicago's leading hospitals.

### PENNSYLVANIA HOSPITAL CELEBRATES 175th ANNIVERSARY

The Pennsylvania Hospital, Philadelphia, one of the oldest hospitals in the United States, is making extensive preparations for the celebration of its one hundred and seventy-fifth anniversary during the summer months. The hospital, which was tentatively organized in 1750 and which began operation as a full-fledged institution in 1751, has witnessed many and varied changes.

According to the arrangements, as recently announced by Daniel D. Test, superintendent of the hospital, the first recognized celebration will be held May 21, when a meeting will be held at the department of the sick and injured. Besides appropriate addresses from prominent speakers, a dinner will be served, and an interesting exhibit of historical material relating to the hospital's founding and development has been planned. Included in this exhibit will be the minutes of the first meetings of the officials of the hospital, signed by the first secretary, Benjamin Franklin. Another meeting will be held a few days later.



Pennsylvania Hospital, Philadelphia

### MARY IMMACULATE HOSPITAL STARTS CONSTRUCTION

Contract for the construction of the new Mary Immaculate Hospital, Jamaica, N. Y., has just been let to Thomas Reilly & Son, New York, according to announcement from the board of managers of the hospital. Construction work on the new 347-bed hospital will begin immediately.

The hospital is situated on Shelton Avenue extending from the present hospital building on the corner of Ray Street to Kenilworth Place, approximately 210 feet.

The development of the hospital is of widespread interest since its planning has been brought to public attention many times during the past few years. The institution will serve a territory covering fifty square miles where, at present, only 15 per cent of the needed bed capacity is available. Therefore, before undertaking the construction of this hospital to serve adequately the needs of the community a survey was made by Dr. Haven Emerson, professor of public health administration, Columbia University, New York, and plans were made accordingly. As soon as the needs of the community were determined the hospital undertook a campaign for \$1,000,000 which resulted in an over-subscription of \$500,000.

In order that the hospital might, from the first, be successfully built from every standpoint and incorporate all the modern hospital features, the board of the hospital in cooperation with the Catholic Hospital Association held a special conference of hospital executives of the country who met in Milwaukee a little over a year ago and discussed the plans for the construction of the hospital. As a result of the advice of experts in the field the plan of future hospitalization has been thoroughly worked out and the present building, which will provide for immediate needs only, is so arranged that it may easily be enlarged to a capacity of 600 beds.

The first unit, for which contracts total \$1,250,000, will also house the administration departments from which all the other departments will radiate.

### COPELAND NOW SUPERINTENDENT OF ALBANY HOSPITAL

Dr. John G. Copeland has been appointed superintendent of the Albany Hospital, Albany, N. Y. He was formerly at the Montreal General Hospital, Montreal, Que., as assistant to Dr. A. K. Haywood, superintendent.

### DR. MAC EACHERN RETURNS FROM NEW ZEALAND

Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, who has spent the last four months studying the hospital systems of Australia and New Zealand has returned, landing at Vancouver, B. C., April 30. He will attend the meeting of the Northwest Hospital Association at Portland, Ore., May 3, and will then return to Chicago in time to be present at the annual meeting of the Hospital Association of the State of Illinois which convenes in Chicago, May 7 and 8.

During his visit to Australia and New Zealand Dr. MacEachern has made an intensive study of the facilities and operation of representative hospitals with the same basic aims governing the inspection of American hospitals by the American College of Surgeons and with a view toward remedying the defects of the system. Advance word from Dr. MacEachern states that both New Zealand and

Australia have many excellent hospitals. On the whole, however, they are yet lacking in dietitians and social workers. Dr. MacEachern has endeavored to remedy the situation by the introduction of the dietitian and the social service nurse.

### NEW YORK ASSOCIATION WILL MEET AT BROOKLYN IN MAY

The Hospital Association of the State of New York will hold its next annual meeting at the St. George Hotel, Brooklyn, May 27 and 28, following the American Health Congress.



C. A. Lindblad, president, Hospital Association of New York State

The tentative program for the two-day meeting includes an afternoon session devoted to nursing and nursing education, a round table discussion on waste in the hospital, sterilizing and the use of controls and the advantages of long term contracts, and a symposium on the care of the industrial injured in a general hospital. The latter subject will be taken up from the viewpoints of the insurance company, the hospital and the surgeon.

### MICHIGAN MOURNS DEATH OF DR. O'BRIEN

The Michigan Hospital Association and the hospitals of Grand Rapids, Mich., are mourning the loss of a capable executive and zealous worker, Dr. Stephen L. O'Brien, who died recently after an illness of several weeks caused by a nervous breakdown.

Dr. O'Brien was president of the Michigan Hospital Association last year and for the past thirteen years has been identified with hospital work in Grand Rapids both as a surgeon and an administrator. He was the first chief of staff of St. Mary's Hospital and was chief of the surgical division during the past year. He organized the free clinic at this institution and remained in charge of it up to the time of his death. He was also a prominent worker in the welfare of the city.



## COMPENSATION, AFFILIATION AND INSIGNIA DISCUSSED BY PENNSYLVANIANS

**W**ITH an attendance of 250 members of the Hospital Association of Pennsylvania, the fifth annual conference was held April 13, 14 and 15 at the Hotel Schenley, Pittsburgh.

In addition to the well attended sessions that were scheduled for morning, afternoon and evening of the three days there was an exhibit composed of the wares of thirty-eight different manufacturers and supply houses of the country. Much of the interest of the delegates and visitors was centered upon the many new devices that were displayed at this year's meeting.

At the last session of the meeting Jessie J. Turnbull, superintendent, Elizabeth Steel Magee Hospital, Pittsburgh, introduced a resolution that was unanimously passed endorsing the movement to select an insignia for hospitals, which would be given over to the American Hospital Association as custodian for its safe keeping when selected.

The proposal of affiliation made by the American Hospital Association through its secretary, Dr. William H. Walsh, met with rather spirited opposition by the members present and many superintendents expressed their disapproval, among them, Elmer E. Matthews, Wilkes-Barre General Hospital, Wilkes-Barre; Dr. George Reese, Trevorton Shamokin and Mount Carmel State Hospital, Shamokin; John M. Smith, Hahnemann Hospital, Philadelphia, and many others. Dr. Joseph C. Doane, medical director and superintendent, Philadelphia General Hospital, offered a resolution that President G. Walter Zulauf who presided appoint a committee to consider the proposal and report back to the association its recommendations. President Zulauf appointed the board of trustees as the committee and on Thursday morning it reported the following:

### Affiliation Proposal Rejected

The special committee appointed by the president to consider the affiliation proposition made by the American Hospital Association begs to report as follows:

"The Hospital Association of Pennsylvania desires an affiliation with the American Hospital Association.

The plan submitted by the American Hospital Association under date of December 31, 1925, however, is not acceptable in that:

It does not permit the Hospital Association of Pennsylvania to determine the qualifications for membership.

It requires membership in the American Hospital Association in order to be eligible for membership in the Hospital Association of Pennsylvania, with the consequent control of the amount of the dues by the American Hospital Association.

The Hospital Association of Pennsylvania would be unable to amend its constitution or by-laws without the approval of the American Hospital Association.

It would permit members of the American Hospital Association to vote in the Hospital Association of Pennsylvania even though they were not members of the Hospital Association of Pennsylvania.

The Hospital Association of Pennsylvania approves in principle the proposed house of delegates for the determination of policies affecting the American Hospital Association and not the sectional associations.

The proposed relationship between the sectional associa-

tions and the American Hospital Association seems involved, impractical and unfair and for these reasons a special committee consisting of the board of trustees of the Hospital Association of Pennsylvania unanimously recommends to the association that the proposed plan of affiliation should not be approved."

Another session that brought forth much discussion was the Wednesday morning session when the subject of possible changes in the present Pennsylvania Workmen's Compensation Law was discussed. Richard H. Landsburg, secretary of labor and industry, was the first speaker, having been asked to attend the meeting. He explained the present law and the workings of the commission and requested the members to ask questions on problems that were not clear.

### Workmen's Compensation

M. H. Eichenlaub, superintendent, Western Pennsylvania Hospital, Pittsburgh, was the second speaker at this meeting reading a paper on "Workmen's Compensation Act in Relation to the Hospital." Mr. Eichenlaub called to the attention of the members the article that appeared in the April issue of THE MODERN HOSPITAL by John A. Lapp entitled, "How Workmen's Compensation Affects the Hospital."

Dr. John H. Alexander, Allegheny General Hospital, Pittsburgh, read the paper that had been prepared by Dr. Otto C. Gaub, Allegheny General Hospital, who was too ill to appear at the meeting. The subject was the "Workmen's Compensation Act in Relation to the Physician." He outlined the difficulties that physicians and surgeons have with the existing laws and urged that some action be taken at the next session of the legislation to change the laws. Dr. Alexander also quoted from Dr. Lapp's article. Others to discuss the subject were: Dr. Reese, Shamokin State Hospital; Frank E. Brooke, Harrisburg General Hospital, Harrisburg; Dr. G. Walter Zulauf, Allegheny General Hospital; Dr. Howard E. Bishop, Robert Packer Hospital, Sayre; W. Maud Newman, superintendent, Sewickley Hospital, Sewickley; May A. Middleton, superintendent, Methodist Episcopal Hospital, Philadelphia; D. Adams, Jefferson Hospital, Philadelphia; A. W. Newell, McKeesport Hospital, McKeesport; H. G. Yearick, Homeopathic Hospital, Pittsburgh; Dr. Edwin R. Lewis, superintendent, Easton Hospital, Easton.

Much concrete value was obtained from the round tables that were held on Wednesday afternoon. Mary B. Miller, R.N., superintendent, Presbyterian Hospital, Pittsburgh, presided at the first one and the following speakers were heard: Dr. I. E. Metzger, president of the Pennsylvania State Board of Licensure; Edith B. Irwin, Greensburg Hospital, Greensburg; H. G. Yearick, Homeopathic Hospital, Pittsburgh; Rena Eckman, president of the Hospital Dietetic Council; Sister Rose, superintendent, Mercy Hospital, Pittsburgh, and May A. Middleton, Methodist Hospital, Philadelphia.

The last two speakers on this section discussed "Comfortable Beds for Patients" and it was pointed out by Miss Middleton that much depended upon the rubber sheeting that was used as protection for the mattress, and that she had found the most success with the type that did not wrinkle, that was stretched tightly and that was strapped to the bed.

Gertrude Heatley, directress of nurses South Side Hospital, Pittsburgh, conducted the second round table on nursing problems. The following contributed to the general discussion: Miss Manley, Homestead Hospital, Homestead; Esther J. Tinsley, Pittston Hospital, Pittston; Miss Delehanty, Homeopathic Hospital, Pittsburgh; Mary B. Miller, R.N., Presbyterian Hospital, Pittsburgh.

One of the most successful dinners that has been given in many years by any association was given on Wednesday evening. Much credit for the success of this undertaking goes to Miss Turnbull who had charge of the arrangements. Music was supplied by the Pittsburgh Criterion Male Quartette and an orchestra, and two speakers were heard. The first speaker of the evening was the Rev. Samuel H. Goldenson, Ph.D., Rabbi of the Rodef Shalom Congregation, Pittsburgh, who delivered an unusually philosophical talk upon "Normal Living;" Dr. Arthur Waldwyn Evans, Springfield, Ohio, was the other speaker and his subject was "America and What It Means to Me."

Thursday morning's session was given over to the discussion of laboratories, with the first paper read by Dr. Samuel R. Haythorn, professor of pathology and bacteriology and director of hygiene, University of Pittsburgh. This was discussed by Dr. W. W. MacLachlan, assistant professor of medicine, University of Pittsburgh, and Dr. Henry K. Mohler, medical director, Jefferson Hospital, Philadelphia.

#### Dr. Brush's Paper

An interesting luncheon session was enjoyed when Dr. Frederic Brush, medical director, the Burke Foundation for Convalescents, White Plains, N. Y., gave a talk on "The Essentials for Convalescent and Sub-standard Health Care." Views of the work that is being done at the Burke Foundation and other institutions for convalescents in this country and abroad were shown. Dr. Brush stated that the subject of chronics and convalescents had been well covered in an article in the April issue of *THE MODERN HOSPITAL* by Dr. Ernst P. Boas, medical director, Montefiore Hospital, New York, and advised those interested in the subject to peruse it. The topic was discussed by Dr. C. C. Cooper of the Kingsley Association of Pittsburgh and Dr. John Fredette, Mercy Hospital, Pittsburgh.

Dr. Henry K. Mohler, Jefferson Hospital, Philadelphia, was chosen president-elect. Janet G. Grant, superintendent, Moses Taylor Hospital, Scranton, was elected first vice-president, Sister Antonia, superintendent, St. Joseph's Hospital, Lancaster, second vice-president. Elmer E. Matthews, Wilkes Barre General Hospital, was re-elected treasurer. Retiring President Dr. G. Walter Zulauf, Allegheny General Hospital, was elected to the board of trustees as was Dr. Lewis, Easton Hospital.

#### CHICAGO PASSAVANT HOSPITAL DRIVE TOTALS \$1,500,000

The ten-day campaign, April 5-15, of the Chicago Passavant Memorial Hospital, Chicago, to secure funds for the erection of a new 200-bed hospital, which was extended to April 21, has netted a total of \$1,500,000 for the project. The hospital will, with the contemplated Wesley Memorial Hospital, also on the McKinlock campus, provide the near north side with the nucleus of a medical centre.

The contributions which came from people in all walks of life in Chicago, scale from an anonymous gift of \$30 donated by a laundress, formerly a patient at the old Passavant Hospital, to the contribution of \$131,400 for the establishing of the entire eighth floor of the hospital as a memorial to the Jelke family, by Mr. and Mrs. John F. Jelke.

The hospital will be an eleven-story structure on a site donated by Northwestern University on the new McKinlock campus on the Lake Shore at Superior Street. Preparations for the construction work will be under way within the next few weeks.

#### EXTENSIVE PREPARATIONS PLANNED FOR MAY 12

Preparations for National Hospital Day indicate that May 12, 1926, will be observed by more hospitals than ever before, that its influence is rapidly extending to all countries and that it is receiving hearty approval from leading officials and clergymen of the country.

This year, under the direction of the National Hospital Day committee, the American Hospital Association has published a bulletin setting forth the purposes and aims of the day and a fund of information as to the various methods that may be used by hospitals and communities in celebrating the day.

In addition to the publicity of the national and local committees the association plans to broadcast information regarding the day on a national scale the night of May 11. Following the precedent established last year, a certificate of award will be given by the association to the hospital whose program is considered the most meritorious, and the award will be made on the night of September 28, 1926, at the Atlantic City convention.

A new feature that aims to promote the national significance of the day this year is the National Hospital Day button which may be secured in large lots from the association headquarters. Posters and folders attractively designed and illustrated for use in every community are also available this year.

#### PROMINENT INDIANA WORKER DIES

Dr. George F. Keiper, one of the founders and the first president of the Indiana Hospital Association, died at his home at Lafayette, Ind., March 18. He served on the staff of St. Elizabeth Hospital for about thirty years and was a member of the staff of the Lafayette Home Hospital for almost twenty years and was oculist and aurist to St. Joseph's Orphanage and the Children's Home and St. Anthony's Home for the Aged since its foundation. He was also a member of the American College of Surgeons and of the American Medical Association, having served as one of its vice-presidents in 1917.

#### A. H. A. FAVORS ADOPTION OF HOSPITAL INSIGNIA

At a meeting of the trustees of the American Hospital Association held March 22 a motion was passed authorizing the president of the association to appoint a sub-committee, consisting of the president and such additional members as he may deem necessary, to take action in the matter of the adoption of an insignia suitable for hospital use, as outlined in an editorial in the March issue of *THE MODERN HOSPITAL* and already endorsed by prominent hospital men and women in all parts of the country.

#### A. H. A. WILL OCCUPY NEW HOME, JULY 1

The American Hospital Association will move into its new headquarters, 18-22 East Division Street, Chicago, July 1, following the removal of an objection by the residents of the community, based on the municipal zoning law. The objection was dropped following an opinion by Corporation Counsel Busch.



## OHIO ASSOCIATION ENDORSES IDEA FOR A HOSPITAL INSIGNIA

A RESOLUTION endorsing the proposed idea of an insignia for hospitals as outlined by THE MODERN HOSPITAL and already endorsed by the trustees of the American Hospital Association, was presented and unanimously adopted by the Ohio Hospital Association at its twelfth annual meeting held at Columbus, April 6 to 8.

In presenting the resolution Frank E. Chapman, director, Mount Sinai Hospital, Cleveland, and chairman of the resolution committee, stated that many hospital administrators for years had hoped that a suitable insignia could be designed, and that by the resolution the Ohio association pledged itself to lend moral support to the project and to adopt the insignia chosen.

Dr. E. R. Crew, superintendent, Miami Valley Hospital, Dayton, was elected president of the association, to serve following A. E. Hardgrove's tenure of office which will end in June 1927. Other officers elected were: Alice P. Thatcher, superintendent, Christ Hospital, Cincinnati, first vice-president; Mary A. Jamieson, superintendent, Grant Hospital, Columbus, second vice-president; Father M. F. Griffin, St. Elizabeth's Hospital, Youngstown, treasurer, and Robert G. Paterson, Columbus, temporary secretary.

### Consider One-Day Meeting

A special committee on rules reported that as the business of the association and the problems of the members could be better transacted in an intensive one day meeting and that it was an imposition on the manufacturers to ask that they exhibit for three days, it might be practical to consider a change. The president was asked to appoint a committee to consider this recommendation and report to the association at the meeting of the American Hospital Association at Atlantic City in September.

Another resolution pledged support to the Ohio Better Milk Council.

A surprise discussion session featured the three day meeting. On Wednesday afternoon a round table was scheduled, with Mary E. Yager, superintendent, Maternity and Children's Hospital, Toledo, as chairman. During the morning session the Rev. A. G. Lohman, superintendent, Deaconess Hospital, Cincinnati, acted as chairman of a partially completed round table that had been taken from the Thursday morning session to complete the short schedule that was originally planned. Of the five speakers on Miss Yager's program, three were unable to be present and the afternoon was thrown open to general discussion, with Dr. Lohman as chairman.

The first question discussed at this session was the state compensation relations, and many superintendents took the floor, among them Dr. E. R. Crew, Frank E. Chapman, Louis C. Levy, superintendent, Jewish Hospital, Cincinnati, and Helen L. Bloomfield, superintendent, Ashtabula General Hospital, Ashtabula. Many problems were presented and solutions to most of them were offered. The consensus of opinion was to the effect that as Ohio now has the fairest of compensation laws relating to hospitals it behooves the hospitals to remain on a friendly basis with those administering these laws.

In the absence of Dr. Charles E. Holzer, Holzer Hospital, Gallipolis, Dr. Lohman called upon Mr. Chapman to discuss the subject "Cost—Rates—Extras—Fees—Collections." Mr. Chapman explained his methods of establish-

ing rates on private rooms, semi-private rooms and ward beds. He decried the general method of special charges, advocating a flat rate to cover all of the patient's expenses each day. He also explained the Mount Sinai system of collection.

Miss Bloomfield read an excellent paper on the "Obligation of Patients to Pay for Hospitalization," in which she reviewed various types and cases that are common to almost every hospital.

One of the important steps taken by the association was the appointment of a committee to review and act upon the suggested provisions of a proposed bill for licensing hospitals and dispensaries in the State of Ohio. The proposed plan was presented on Thursday afternoon by Arden E. Hardgrove, superintendent, City Hospital of Akron, Akron, as chairman of the legislative committee. This measure aims to raise the standard of hospitals in Ohio and to prohibit what are termed shyster institutions of questionable standing.

Dr. John E. Monger, director, State Department of Health, Columbus, was a speaker on Wednesday afternoon, taking for his subject "State Department of Health Relations." He explained the functioning of his department in relation to the hospitals of the state.

Mr. Chapman was the chairman of the Wednesday morning round table when five papers were read. Lawrence Davis was called upon to express the sentiments of the Hospital Exhibitors' Association, which was represented at the meeting by eighteen manufacturers.

Prof. William R. Sears, Ohio State University, read a paper on "Landscaping." He stated that when planning a hospital it was essential to consider first the practical side of landscaping and second, the beautifying effect. He explained that well laid out grounds can be more economically cared for than those that are poorly planned, that with the various driveways, walks and lawns properly placed the hospital could be more efficiently operated and that usually the scenic effect would take care of itself.

### New Dietetic Methods Discussed

Gustave A. Drach, architect, Cincinnati, and president of the Neil House, Columbus, read a paper on "Problems Common to Hotel and Hospital Construction and Operation," in which he told of his experiences in planning both types of buildings.

An unusually instructive talk was given by George C. Mitchell, Coshocton, on the history and manufacture of chinaware. He illustrated his remarks with exhibits of pieces of china in various stages of manufacture.

Bertha Beecher, dietitian, Christ Hospital, Cincinnati, spoke upon dietetics and told of new means and methods of operating the dietetic department as well as the kitchen generally. Miss Beecher brought many new ideas to the meeting and her paper was appreciated by the superintendents as well as by the members of the Ohio Dietetic Association who attended this session.

As the special feature of this annual meeting Dr. Joseph C. Doane, medical director and superintendent, Philadelphia General Hospital, Philadelphia, was the speaker. He was introduced by Dr. C. H. Pelton, superintendent, Elyria Memorial Hospital, Elyria, the president of the association. Dr. Doane spoke on "Hospital Objectives."

On Tuesday evening the annual dinner was held in the ballroom. Dr. C. L. Hyde, Springfield Lake Sanatorium, Akron; Dr. T. A. Ratliff, Grand View Sanatorium, Cincinnati; Dr. William H. Pritchard, Columbus, and Dr. A. C. Bachmeyer, president of the American Hospital Association and superintendent, Cincinnati General Hospital, Cincinnati, were the speakers. Preceding the speeches came the introduction of former presidents of the association, including Father Maurice F. Griffin, Rev. A. G. Lohman, Dr. E. R. Crew, Dr. A. C. Bachmeyer, F. E. Chapman, B. W. Stewart, superintendent, Youngstown Hospital, Youngstown, and others. A. E. Hardgrove, the new president, was also introduced.

Thursday morning's session was given over to round tables conducted by B. W. Stewart and Starr Cadwallader, Cleveland Hospital Council. Dr. P. B. Brockway, Toledo, spoke on "Medical Inspection of Schools;" Mrs. Zoe McCaleb, Columbus, on "Cooperation With Public Health Nurses;" Gertrude Steuer, social service worker, Mount Sinai Hospital, Cleveland, on "Social Service and Out-Patients;" Dr. E. R. Crew on "Out-Patients," and Dr. H. E. Kleinschmidt, Columbus, on "Clinics."

The subject of publicity and financial campaigns was discussed in Dr. Lohman's round table by Mr. Chapman, who outlined the work that had been and was being done in Cleveland. Mr. Hardgrove was also a speaker at this session on "Budgets." He explained the principles that he has worked out in Akron.

### OHIO DIETITIANS DISCUSS PROBLEMS AT COLUMBUS

Three interesting sessions were held by the Ohio Dietetic Association at its annual meeting held in conjunction with the meeting of the Ohio Hospital Association at Columbus, April 6 to 8.

In the absence of the president, Miss E. M. Geraghty, Lakeside Hospital, Cleveland, Marion Peterson, Miami Valley Hospital, Dayton, secretary, presided.

On Wednesday afternoon Helen Sawyer, Columbus, presented a paper on "Administrative Problems in Tea Room Management," and J. A. Mills, Columbus, spoke on "Restaurants and Dietetics."

On Thursday morning, Robert E. Neff, administrator, Indiana University Hospitals, Indianapolis, spoke on "Unified Dietetic Service for University Group Hospitals." Faith Lanman, University Hospital, Columbus, spoke on "Present Day Tendencies in the University Preparation for Hospital Dietetics."

A business meeting followed the papers on Thursday morning.

### COLORADO GENERAL HOLDS FOUR-DAY CLINIC FOR PHYSICIANS

On March 23 to 26 inclusive, there was held at the Colorado General Hospital, Denver, Colo., under the supervision of Dr. Edgar A. Bock, superintendent of the institution, a four-day clinic to which was invited all of the licensed physicians in the state of Colorado.

This was a new venture and was conducted purely for the purpose of offering a short intensive course of study for the doctors of the state, and at the same time bringing to their attention the possibilities for the treatment of their patients available in this institution. The clinic was held under the auspices of the University of Colorado School of Medicine and the Colorado General and Psychopathic Hospitals and was attended by approximately 650 physicians and surgeons from all parts of Colorado and

many surrounding states of the West. According to Dr. Bock the clinic was planned to serve three specific purposes: (1) Acquaintance of the visiting physicians with the advantages of the hospital and the school; (2) demonstration and instruction on the newer advances in medicine to the doctors; (3) familiarization of the doctors of the state with the methods of getting patients into the hospital, the type of patients cared for and the methods of operation.

### OAK PARK SUPERINTENDENT DIES

E. J. Hockaday, superintendent of the West Suburban Hospital, Oak Park, Ill., died March 30, as a result of pleuro pneumonia. Mr. Hockaday was forty-nine years of age and had been superintendent of the West Suburban Hospital for eight years. The institution has 250 beds and is building an addition that will increase the capacity to 500 beds. Last year a new nurses' home having 185 beds was completed. Mr. Hockaday has been the moving spirit in the expansion of the hospital and the plans were all developed in accordance with his ideas. Before coming to Oak Park Mr. Hockaday was superintendent of the Post Graduate Hospital, Chicago.

### DR. O'HANLON JOINS HENRY C. WRIGHT AS HOSPITAL CONSULTANT

Dr. George O'Hanlon, formerly superintendent of Bellevue and Allied Hospitals, New York, and now director of Jersey City Hospital, Jersey City, N. J., has become associated with Henry C. Wright in hospital planning under the name of Wright and O'Hanlon, hospital consultants, 289 Fourth avenue, New York. Mr. Wright is director of the Hospital and Institutional Bureau of Consultation, New York, and consultant on rural hospitals for the Commonwealth Fund, New York.

In addition to consultation on general hospitals, they will consult on hospitals and sanitariums for the insane. Dr. O'Hanlon for seventeen years was in the insane hospital service of New York State. They will also specialize on municipal hospitals, with which both have had many years of administrative experience.

### ASSURE \$4,500,000 MEDICAL CENTRE FOR UNIVERSITY OF IOWA

With a \$900,000 teaching unit nearing completion, the new \$4,500,000 medical centre at the University of Iowa, Iowa City, made possible by a gift of \$2,250,000 from the Rockefeller Foundation, and an equal appropriation from the state, is assured completion within the next few years. Bids for the huge new university hospital were called for March 20 and were to be awarded within sixty days.

The new building, which will occupy an area 500 by 300 feet on the west side of the Iowa river, will afford a total capacity of 1,000 beds with the accommodations now available in the children's, psychopathic, and other special hospitals of the university.

### OPEN SANATORIUM FOR EXCLUSIVE USE OF SOCIETY OF JESUS

The Seven Springs Sanatorium, Monroe, N. Y., for the exclusive use of the members of the Society of Jesus, was recently opened for the reception of patients. The building, located in an historic setting, at an altitude of 1,000 feet, is a three-story stucco building with modern equipment throughout.



## THE OPEN FORUM

*Thoughts, opinions and criticisms are invited for these pages from readers in all departments of hospitals and related services. Please address letters and other communications to the Editor, THE OPEN FORUM.*

### HOSPITALIZATION OF PNEUMONIA CASES

**A**LL readers of THE MODERN HOSPITAL will recall the article "The Hospitalization of Pneumonia Cases (Report of the Chicago Pneumonia Commission)," by C. C. Pierce, M.D., senior surgeon of the U. S. Public Health Service, District No. 3, in the December, 1925, issue of this magazine.

The subject is of live interest to all hospital superintendents and members of medical staffs. The publication of Dr. Pierce's article has called forth so much discussion that the editors have decided it is advisable to present the following further comments:

**HUGH S. CUMMING, M.D.,** Surgeon General,  
U. S. Public Health Service:

"In compliance with the request contained in your letter of January 22, 1926, the following comment is made on the recommendations of the Chicago Pneumonia Commission with reference to the hospitalization of pneumonia cases:

"It is understood, of course, that on several of the points raised in the recommendations of the Chicago Pneumonia Commission there might be legitimate difference of opinion; particularly is it likely that there would be some disagreement when the subject is looked at from the point of view of the health officer and when looked at from the point of view of the hospital administrator. In this reply we have concerned ourselves with the latter aspect of the case, inasmuch as this follows the indication of your letter of January 22. It is believed that we are without sufficient data to warrant the acceptance of the recommendations in their entirety—at least we are not acquainted with facts that would justify all of the requirements, and restrictions as given are based largely—indeed almost exclusively—on experience in several of the larger hospitals operated by the Public Health Service. Taking up the recommendations in order we would say:

"1. With respect to visiting, it is believed that this should be regulated primarily in the interest of the patient's condition. We are not acquainted with any grounds that would justify limitation of visiting to cases of actual emergency. It may be admitted that the exception to the rule laid down by this commission might be so liberally construed that we would have no difficulty in agreeing with this recommendation.

"2. We agree, in principle, with reasonable isolation, believing that cubicles, or the separation of beds by

screens, afford the isolation that is required. The details referred to in this recommendation appear to be reasonable.

"3. If the precautions indicated under the second recommendation are successfully carried out, there appears to be no special need for this restriction, although it would be simple enough to place pneumonia patients in beds in such a manner as to accomplish what is sought. It is a serious question as to whether the consideration of possible cross infection of different 'types' would justify the work required to 'type' every case.

"4. We agree with this in principle, although, as indicated in the preceding paragraph, if the precautions indicated in the second recommendation are observed, there should be no serious difficulty.

"5. We agree with this, and believe it represents practice long established in our own hospitals.

"6. This is considered a reasonable precaution, although we could scarcely subscribe to slavish adherence to a rule covering this point.

"7. We see no reason for insisting on a period of isolation such as is indicated, and, indeed, the criteria by which the non-infectivity of the patient would be established might be a matter of considerable difficulty.

"8. This represents good practice, and we agree without reservation.

"9. We see no special point to be gained by 'typing' the organisms found in pneumonia, except from a research point of view, even if the disease prevails in epidemic form in the hospital."

**WILLIAM H. PARK, M.D.,**  
Department of Health, New York:

"I think there is no question that the quarantine of cases of pneumonia will lessen the spread of infection of virulent pneumococci and so will lessen other cases of pneumonia.

"On the other hand, it is difficult to show by any individual infections that this is necessary because only a small percentage of those who become infected also suffer from other conditions which lower their resistance and lead to the development of pneumonia.

"It probably is wise for other cities to watch the results that will follow the quarantining of pneumonia cases in Pittsburgh. If the results prove striking, it will then be necessary for other cities to follow Pittsburgh's example. There seems to be sufficient proof that the germs from cases suffering from disease are more virulent than similar germs coming from carriers. It would therefore seem that the strict quarantine of pneumonia cases would lessen the average virulence of pneumonia in a community."

C. F. TENNEY, M.D., Chief of Medical Service, B,  
Fifth Avenue Hospital, New York:

"I have been very much interested in reading Dr. Pierce's article in *THE MODERN HOSPITAL*. I have always been in favor of hospital treatment for pneumonia and I shall try to give my reasons briefly.

"In the first place, while the article states that the death rate from pneumonia is much higher in hospital treatment, I think it is stated very clearly why this is so. If the hospital were given an equal number of days' treatment in the beginning of the disease, the death rate would be lower in the hospital than it is at home. Thus comparing days of illness and treatment given, you would find that in many cases of pneumonia, taking nine days, as an average duration of illness, considerably more than one-half of this time was given over to treatment at home until the patient became desperately ill and then was rushed to the hospital. Many of the cases of pneumonia from the poorer classes which come to the hospital do have a lowered resistance because of poorer food and unhealthy sleeping quarters, and probably the patient has worked for the first day or two of his illness.

"I also agree with the author that the greatest incidence of pneumonia is in the old or in the very young. Also the death rate is highest in these groups of cases and they are more frequently sent to the hospital because they are more difficult nursing cases than those in middle life.

"The plea for early diagnosis of all respiratory infections and transfer to the hospital as soon as the diagnosis is made, this transfer being done by ambulance, will not materially increase the death rate because of the transfer.

"The advantages of hospital treatment are so much greater that I think the danger in moving the patient is offset by the superior type of care and nursing that can be given. The great value of checking the clinical findings with both x-ray and laboratory tests enables one to follow more closely an extension of the involvement, the earlier recognition of complications such as pleurisy, empyema, abscess of the lung, decompensated heart, and endocarditis. The prompt treatment, as these complications arise, not only saves many lives but lessens the days of illness. The isolation of the patient from other members of the family can be carried out in the hospital, and the danger of the spread of infection from one to the other is much more easily controlled.

"We know how infectious is the influenzal pneumonia and probably second to that the Type 1 lobar pneumonia is very readily communicable from one to another. In both of these types of pneumonia it was so well illustrated in the recent World War how these contacts spread the disease. In the epidemic influenzal types, it traveled just as fast as people traveled. The lobar type, of which we had one very good example in a detachment of colored troops who were loaded at Brest, all of whom were ambulatory, was well illustrated as to the communicability of the disease and is a very important epidemiological factor. These soldiers were kept in close quarters. Under these conditions, by the time they had docked in the United States, sixty-five cases of Type 1 pneumonia were taken from this same group, having developed while in transit.

"In the home, members of the family frequently relieve the nurse. Children of the family frequently climb on the bed and for that reason the spread of the disease can be much more easily controlled in institutions. There is more accurate nursing carried out in hospitals than

in the home; more accurate charts are kept; more frequent blood counts are made; the urinary examination is made more frequently, and with the use of the portable x-ray, pictures can be taken of the patients in bed without even moving them to the laboratory.

"At the pneumonia season of the year when the doctor is busiest making his rounds, the complications that are most common in this disease are often overlooked, until they have become a dangerous factor in the recovery of the patient.

"This is a brief statement of the facts as I see them with regard to the care of pneumonias and while nursing is a very large factor, yet the careful interpretation of symptoms, the anticipation of oncoming heart failure, watching for increased dullness at the bases, suggestive of accumulation of fluid that later may become pus, being constantly on the lookout for urinary findings for suppression of urine and uremia, all can be more closely followed in institutions than in the home.

"While I have not mentioned the serum treatment, I have had considerable experience especially with Type 1 serum. I think it has been disappointing that while we recognize there are four types of pneumococcus infection, the only one that has responded to treatment with the serum has been the Type 1. Most of these cases, with proper nursing, get well without the serum and I am inclined to believe that there is little use in typing the sputum at the present time because if the Type 1 serum is of no great value and we have no serum for Types 2, 3 and 4, most of the pneumococci then would be treated alike. The clinical divisions of the broncho—and the lobar types require very little difference in their care, so that the plea is for early diagnosis, hospital treatment, laboratory aid, and for an early recognition of any complications."

JOHN D. SPELMAN, M. D., Superintendent,  
Touro Infirmary, New Orleans, La.:

"We appointed a committee to consider the recommendations of the Chicago Pneumonia Commission, and are transmitting the comment of each member of the committee which we trust will reach you in time for publication:

ISAAC IVAN LEMANN, M.D.,  
Touro Infirmary, New Orleans, La.:

"I wish to make the following comments on the recommendations for the Chicago Pneumonia Commission:

"1. General visiting of patients with pneumonia should be prohibited. This, however, is subject to the comment that critically ill patients should not be deprived of the comfort of the attendance of at least one member of the family.

"2. The number of cases of pneumonia treated in Touro Infirmary and our limited facilities for isolation would not permit the inauguration of the rule against the treatment of pneumonia in the general wards. I am heartily in favor of the cubicle system if ever we can establish it. In the meantime we should attempt to establish isolation by means of screens and we should insist upon proper disinfection.

"3. The comment made under 2 is to be made as to the isolation of different types of pneumonia.

"4. Isolation by means of screens will in a large measure cover the points indicated in this paragraph. Particular attention might be given to the avoidance of placing pneumonia patients in the neighborhood of patients recently operated upon or suffering from debilitating conditions. In this connection I wish to emphasize the



comment I made in our discussion, namely that pneumonia patients should not be treated in semi-private rooms, that is, rooms occupied by two patients.

"5, 6, 7, 8 and 9. I am heartily in accord with all of these proposals."

**L. R. DEBUYS, M.D.,**  
Touro Infirmary, New Orleans, La.:

"With reference to the recommendations of the Chicago Pneumonia Commission, copy of which you sent me requesting some comment from me, I beg to report as follows:

"Recommendation 1. I am in accord with this recommendation as it is a safeguard to the patient, to the visitor, and to the layman with whom the visitor comes in contact.

"Recommendations 2, 3, 4, 5 and 6. I am in accord with.

"Recommendation 7. The isolation of the pneumonia case should continue as long as the disease lasts. Just when the non-infectivity of these convalescents begins is a problem that should be interesting to work out, as a large percentage of individuals harbor the germs of pneumonia in their throats without being sufferers from the disease.

"Recommendation 8, with its sub-division, I am in accord with.

"Recommendation 9, I see no objection to, but just how much good will come of the knowledge of those who have pneumococci in their throats, and the typing of these pneumococci, may be of interest, but as already stated the germs are frequently present without the existence of disease. It might be interesting to type the pneumococci and to keep those individuals with a type different from the organism infecting the individual separate so as to prevent a mixed infection. At the same time the individual who is ill may be immune to the types found in the carriers.

"The entire subject is an extremely interesting one and offers food for thought from many angles. I do believe that gowns should be worn by those nursing patients ill with pneumonia and by those entering a room in which a patient is suffering from pneumonia. Precautionary measures as in the cases of other infectious diseases should be practiced."

**RANDOLPH LYONS, M.D.,**  
Touro Infirmary, New Orleans, La.:

"In commenting on the recommendations of the Chicago Pneumonia Commission I wish to state that as a whole I am in entire accord with them. There are a few exceptions that might be made with regard to the disease in this latitude. First, pneumonia is not as common with us as it is in the East and Northwest. Typical lobar pneumonia is far less frequently met with here; lobular pneumonia is the prevalent type here.

"As regards recommendation No. 2, that pneumonia should not be treated in a general ward of a hospital, I may say that I have never as yet seen a contact case from bed to bed when patients were properly separated by screens.

"As regards recommendation No. 3, we have never found it necessary to separate pneumonias of different types except by screens between the beds occupied by such patients in the ward.

"As far as the remaining recommendations are concerned they appear to me excellent and should be followed, although in this part of the country the problem of pneu-

monia is apparently much less acute than it appears to be in Chicago."

**DAVID P. BARR, M.D.,** Physician-in-Chief,  
Barnes Hospital, St. Louis, Mo.:

"It is recognized that pneumonia is an infectious disease and that the organisms may be transmitted from the patient to the throat of the attendant. It is believed that the chief method of transmission is by spray from coughing, or from dust containing the sputum of the patient. For this reason, it is believed necessary that the strictest precautions be observed to prevent the patient coughing in the face of the attendant and to prevent the sputum being spread.

"Nurses are instructed to wear masks and gowns during routine care of the patient; sputum is kept in cups which may be thoroughly disinfected. All sputum is destroyed by antiseptics or burning and any sputum accidentally spilled is treated as 'infectious material.'

"We have not believed it necessary to isolate our pneumonia patients in a separate room or even to cubicle them in the ward. We do not require our physicians to wear masks and gowns when in attendance upon the patient, believing that except for spray infection the opportunity of the physician for spreading the disease is very slight. To guard against this possibility the nurse holds a towel in front of the patient's face during the examination by the physician.

"Our procedure would, of course, be different in the presence of pneumonia epidemics, such as were seen during the war."

**CHARLES L. MINOR, M.D.,**  
Asheville, N. C.:

"I feel in the first place that a distinction should be made between lobar pneumonias and broncho-pneumonias. While the former are probably more infectious, the latter in my experience, cough a great deal more, and I think that the amount of cough is the chief thing to be considered in the study of this problem. In our large cities, lobar pneumonia in the winter months, and also broncho, is so common that to treat it as an acute infectious disease like small-pox, would put a great hardship upon many worthy people. On the other hand, were you a patient in a general hospital, to have a coughing pneumonia case in the next bed would be a distinctly dangerous thing for you. The thing then will be, while allowing them into general hospitals, to eliminate the danger of their transmitting their disease to other patients.

"Recommendation No. 1 I heartily agree with, if care is taken to see that close relatives are not, by stupid interpretation of rules, prevented from seeing dying patients.

"As to recommendation No. 2, I do not feel it is practical to ask cities to build special pneumonia hospitals or to keep up special pneumonia wards, and I believe that the proper and strict use of screens and thorough antiseptics in the care of the patient meet the situation in the majority of cases.

"As to recommendation No. 3, I believe that the proper use of screens makes this unnecessary. As to No. 4, while again I believe that proper screens can protect neighboring patients, it is desirable to separate pneumonia patients from these as far as possible.

"No doctor would disagree with recommendation No. 5. As to No. 6, the period of isolation should cease with the cough and expectoration, save that where there is persistent expectoration the bacteriological determination of non-infectivity should be our guide. I heartily agree with

No. 8 and all doctors will agree with the wisdom of No. 9.

"As I think I have made plain, the point I would stress is my belief that proper screening can be a perfect protection to neighboring patients. Proper disinfection, a perfect protection to the nursing staff and the proper warnings to affectionate relatives, accompanied by close supervision of the visit should protect these. Further, I think it would be a pity if the public were taught to regard pneumonia like scarlet fever, measles or small-pox, and that such an attitude is neither practically nor scientifically necessary."

**WALTER R. STEINER, M.D.,**  
Hartford, Conn.

"In the study of the recommendations on the hospitalization of pneumonia cases of the Chicago Pneumonia Commission, it seems to me that the first recommendation, to exclude the visiting of persons in the hospital suffering from pneumonia, is rather harsh. It seems to me also unnecessary.

"The second recommendation, I also consider unnecessarily harsh. In my eighteen years as visiting physician

to the Hartford Hospital, I have never seen an epidemic of pneumonia in that institution; neither do I know of any friends of the patients who have contracted the disease by visiting them.

"I think the third recommendation is good, as it might lead to a mixed infection, but, again it is not absolutely necessary.

"The fourth recommendation I heartily agree with. Too close contact with pneumonia cases of persons with decreased resistance might insure the latter contracting pneumonia.

"I am also in favor of the fifth recommendation, as it might tend to decrease the number of cases.

"The sixth recommendation I should also agree with.

"Concerning the seventh recommendation, it seems to me it is hard and will be hard to determine the non-infectivity of the organisms that cause pneumonia. Netter showed years ago that 20 per cent of normal individuals had the pneumococcus in their sputum and Sternberg was able to kill animals from a septicemia due to the pneumococcus which he found in his own sputum.

"The eighth and ninth recommendations I heartily concur with."

## A SYMBOL OF HOSPITAL SERVICE

**SISTER ZOE, R.N.,**  
Mary's Help Hospital, San Francisco, Calif.:

"It is indeed a big problem to represent and crystallize the entire field of medicine in its broadest sense into a simple device, readily interpreted by all as characteristic of the present day hospital. However, you have the assurance of our interest and best wishes that your desire may be fully realized."

**OMER B. MAPHIS, Superintendent,**  
Bethany Sanitarium and Hospital, Chicago:

"I noticed an editorial in the March issue of THE MODERN HOSPITAL, relative to an insignia of service for hospitals. It seems to me that since hospitals are more or less of a product of Christianity no better insignia could be found than a picture of the first hospital as given by Jesus Christ in what is commonly termed the 'Good Samaritan.' While it is true that others than Christians are backing the hospitals, yet I doubt whether hospitals would ever have come into existence without the influence of the great Teacher of Christianity. At least we do not find them in any countries today unless Christianity has influenced that country to a greater or less degree."

**G. R. NOTSON, D.D., Superintendent,**  
Methodist Hospital, Sioux City, Iowa:

"I have carefully read the editorial 'Insignia of Service.' It is difficult to think of an insignia that might be universally accepted. I know of no thought symbolized more impressively than the one found in the picture of the Good Samaritan. The truth is a universal one of mercy and help."

**S. G. DAVIDSON, Superintendent,**  
Butterworth Hospital, Grand Rapids, Mich.:

"I think the idea is fine, inasmuch as hospitals have gone hand in hand with civilization they should have an emblem to symbolize them."

**AMY BEERS, Superintendent,**  
Hackley Hospital, Muskegon, Mich.:

"It seems to me to be a splendid idea and I can see no reason why a suitable insignia could not be found and developed in such a manner that it might mean as much to all hospital workers as the Red Cross signifies to all people.

"Copies of My Pledge and Creed are used daily, and there are countless ways in which a suitable insignia might be a great service.

"I shall be very glad indeed, to keep this matter in mind and refer to you any suggestions that may occur to me."

**K. H. VAN NORMAN, M.D., Director,**  
Western Reserve University Hospitals, Cleveland:

"An excellent idea! With THE MODERN HOSPITAL's many hundred readers you should be able eventually to be furnished with a suitable and distinctive design to symbolize the hospital."

**E. H. SNAVELY, M.D., Superintendent,**  
City Hospital, Newark, N. J.:

"I think your editorial in this month's MODERN HOSPITAL in reference to a symbol which would be universal for the use of the word 'hospital' is very timely and a good idea. I think some symbol which would mean hospital, as the caduceus implies the physician, would mean a great deal to hospital people.

"I have no particular symbol to suggest but think that one should be adopted that would apply to hospitals generally and not only to certain individual groups of institutions."

**C. G. PARNALL, M.D., Medical Director,**  
Rochester General Hospital, Rochester, N. Y.:

"I approve heartily of your plan of developing insignia for the hospital."



## INCREASING SERVICE THROUGH NEW FACILITIES AT HAMILTON, OHIO

By Sister M. Gonzaga, Mercy Hospital,  
Hamilton, Ohio

**I**N RESPONSE to the hospital needs of Hamilton, special consideration has been given to the surgical unit and the children's department of the new addition to Mercy Hospital. Heretofore there have been only thirty infant cribs available to all Hamilton—a town of over 48,000 having an available territorial population in excess of 100,000. The surgical service also was much in need of enlargement.

By the recent addition, the hospital has been able to enlarge the x-ray and physiotherapy departments as well as to give additional space to the laboratory. On the upper floors increased accommodations will be given the maternity department and the nursery.

Furthermore, Hamilton has been suffering from the lack of out-patient service. The accompanying line drawing shows how this need has been filled. The out-patient department is considered unusually effective in its layout, since it embodies many of the ideas obtained by the Sisters and the architect while on their numerous trips to other cities for the purpose of inspecting and studying hospitals and particular departments. This research work has done much to prevent the mistakes that might otherwise have been made, and has suggested many worthwhile ideas in the way of economy and convenience.\*

All dining rooms, together with the kitchen, refrigerating plant, storage rooms and other auxiliary spaces are located on the ground floor. Here also are rooms for graduate nurses, Sisters, interns, doctors, orderlies, engineers and office help. The out-patient department has also been located on the ground floor, with its entrance on Front Street. The out-patient department occupies nearly an entire wing; the opposite wing houses the

pharmacy, milk laboratory and the administrative offices.

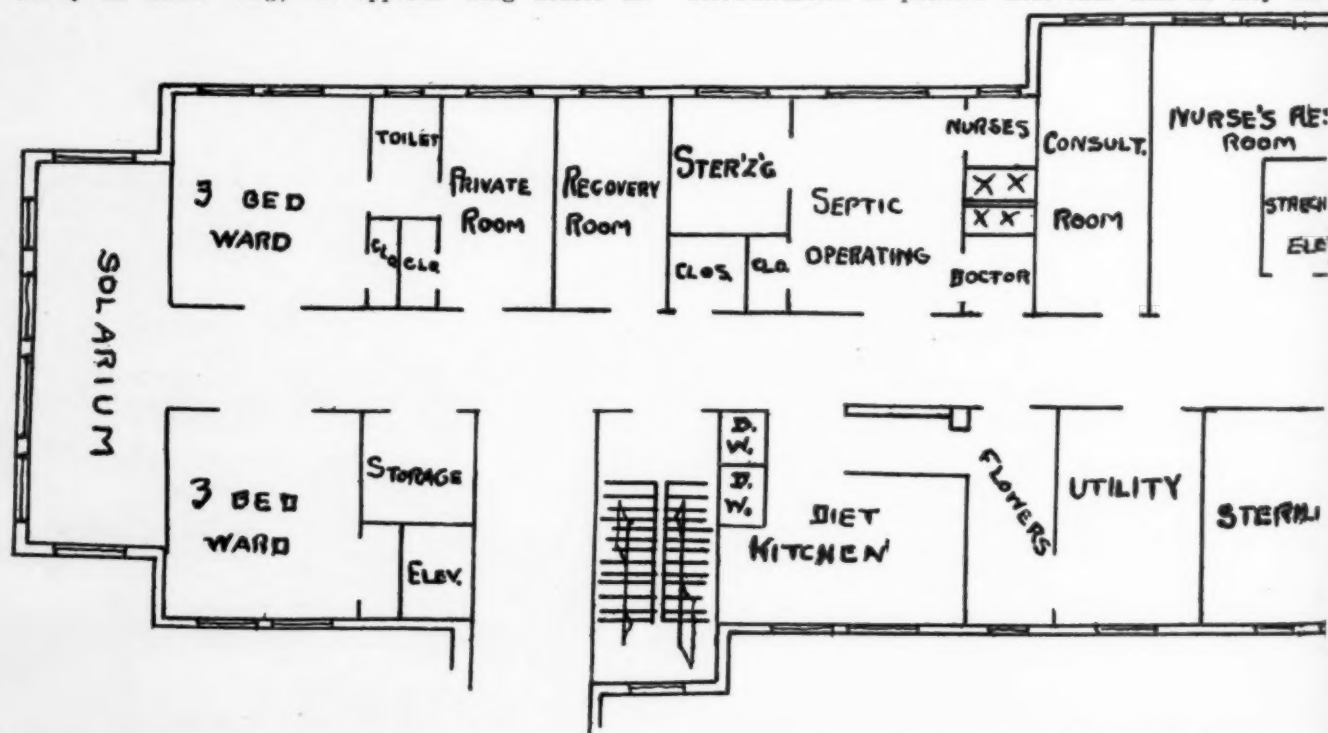
A small addition for contagious cases will be constructed to the rear of the present building. It will be separated from all other parts of the hospital and will be equipped with a separate diet kitchen and utility room.

On the main floor, known as the second floor, the west wing will be devoted to the medical section. Most of the rooms in this wing will be private, only a few of them being semi-private, or two, three and four-bed wards. Bath facilities have been so arranged that the rooms can be used jointly or separately, as needed.

The east wing of this floor has been divided into three large wards for children. Adequate bath and toilet facilities have been provided for the children, as will be seen by the accompanying illustration. From this drawing will also be seen the spacious solarium that will be used for both treatment and recreational purposes. Such a solarium has been duplicated on each of the floors, thus affording an exceptionally well lighted and equipped sun parlor for all classes of patients.

At the present time a portion of the third floor east wing and the entire third floor west wing will be devoted to sleeping rooms for the thirty Sisters.

The west wing on the fourth floor will be devoted to the surgical department. This unit consists of two large, major operating rooms, one minor operating room, two eye, ear, nose and throat rooms, a septic operating room with small sterilizing room and doctors' room adjacent. On this floor also are the rest rooms for interns and nurses, plaster cast room, and chart and record rooms. Recovery rooms have been provided on this floor for the accommodation of patients until such time as they can



Floor plan showing the surgical unit of the

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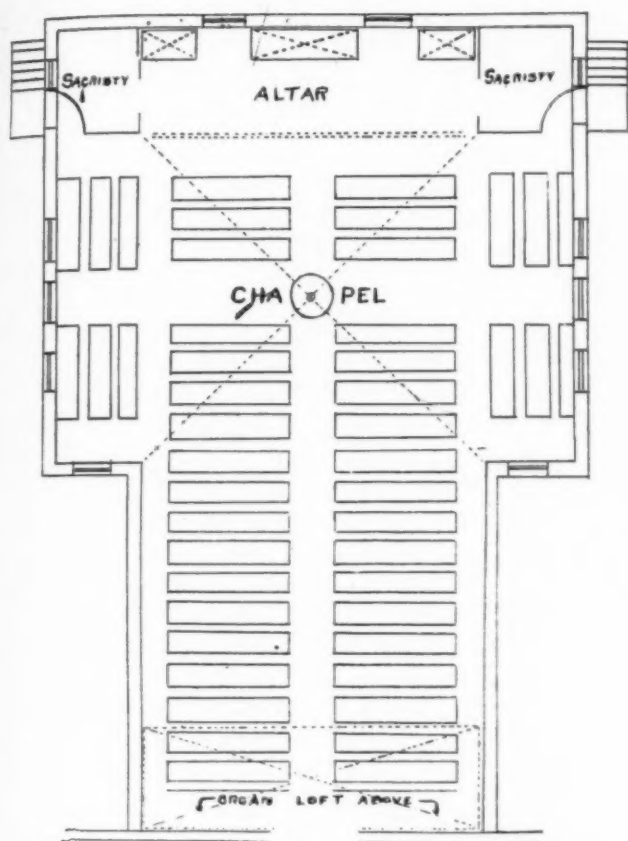
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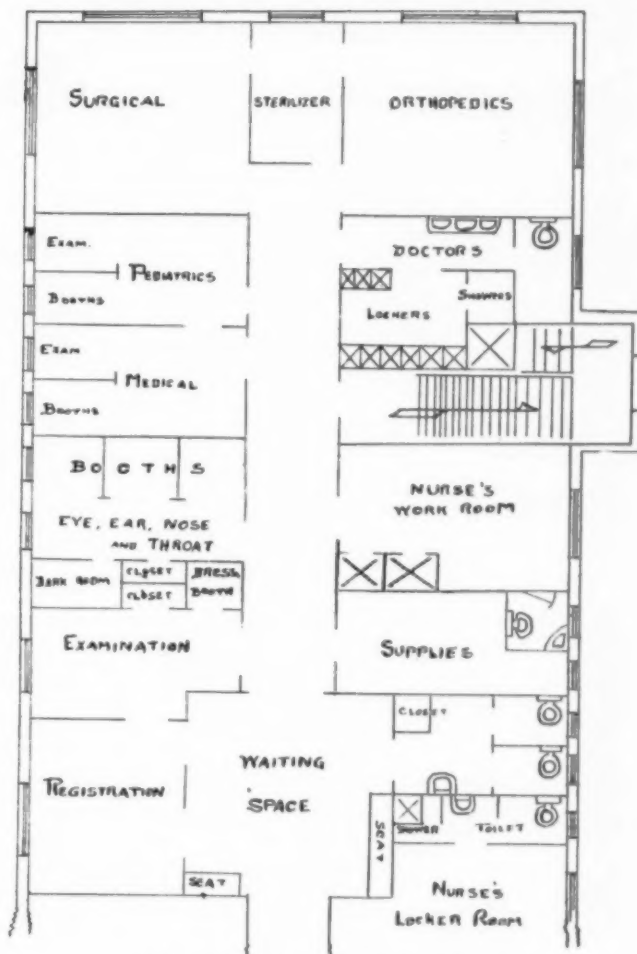


Floor plan of the chapel.

be moved into their permanent rooms. This facility is not only appreciated by the temporary occupant but by other patients as well, since a patient recovering from an operation frequently disturbs neighboring patients.

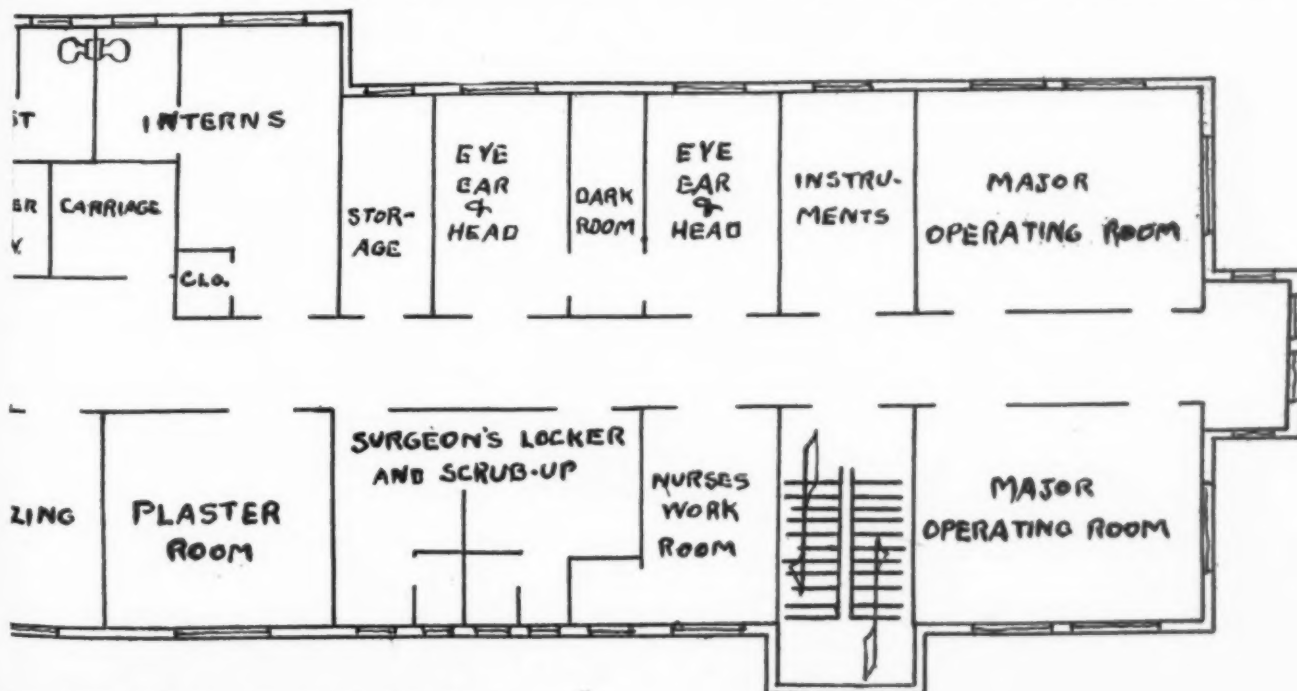
A silent signal system will be installed that is believed will greatly lessen noise in the institution and will enable the registrar to locate immediately any physician in the hospital.

Mercy Hospital owns a large apartment house, di-



The layout of the out-patient department.

rectly across the street, that has been converted into a home for nurses. The addition and the rearrangement of the other departments of the institution place Mercy Hospital in a position to meet adequately the needs of the community in the curing and prevention of disease.



recent addition to the Mercy Hospital, Hamilton, Ohio.



## A NOTABLE EXAMPLE OF FRATERNAL HOSPITALIZATION

By Carl A. Erikson of Richard E. Schmidt, Garden & Martin, Architects, Chicago, and James M. Kirkpatrick, National President, Security Benefit Association, Topeka, Kans.

**F**EW people realize what an important place the fraternal beneficiary society or fraternal organization plays in the American social fabric. Although many of these organizations exist for social purposes only they often have offshoots of an eleemosynary nature, usually orphans' or old people's homes, or occasionally a tuberculosis sanatorium. In addition to this type of fraternities there is another in which mutual protection against sickness or death is the primary function, with the social features somewhat submerged. Such organizations range from small sickness and burial societies up to large insurance groups of great strength and of many years' standing. The numbers and strength of these insurance societies may be gauged by the fact that they have \$10,112,528,965 insurance in effect payable to 10,195,017 members, according to the best available statistics for 1924.

The Security Benefit Association is one of the largest and strongest of these fraternal insurance societies, having a total of 250,000 members. In addition to its insurance premium the members are assessed five cents a month (recently raised to ten cents if, and when needed) for the construction and maintenance of an orphans' home, old people's home, and a hospital, all of them entirely free to members. In the course of fifteen years these nickels have rolled up until the society has over 400 acres of beautiful land about five miles west of Topeka, Kans., upon which it has completed six fireproof buildings, in addition to the necessary farm buildings, and hard surface roadways. The whole represents an investment of well over \$1,000,000.

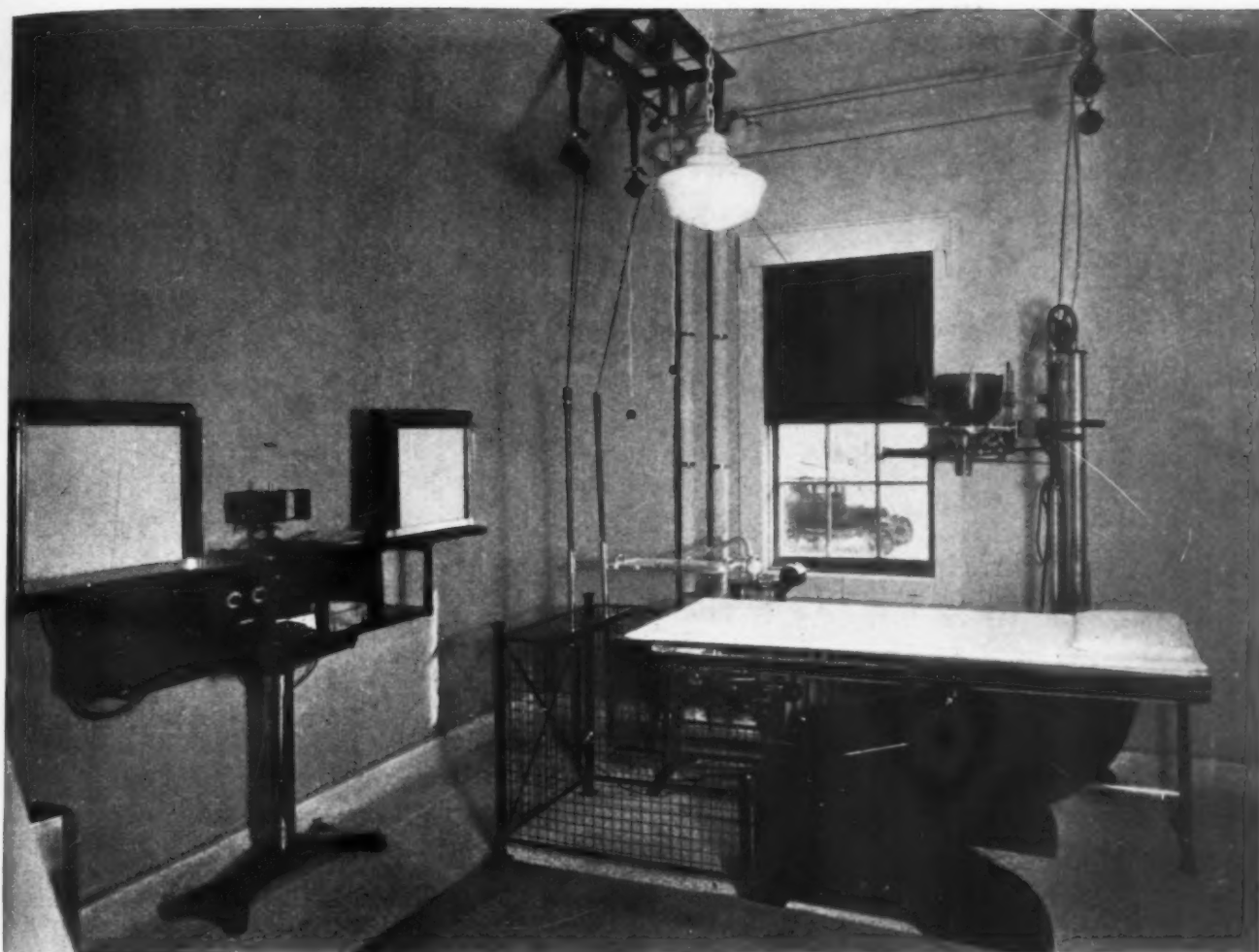
The property selected for the buildings was unusually well located. The panorama to the south, east and west extends for several miles over the gently rolling farm land. A short distance north of the hospital the land slopes sharply downward to the Kansas River. This slope is well covered with trees that afford effective protection against the force of the north winds. A ravine that ran almost due north and south from the main highway, Sixth Avenue, gradually tapering off into the crest of the property, bisected the building site. After careful study a "V" type plan was adopted, with the hospital at the head or point of the "V" and the buildings for the aged on the east stem. The plans contemplate a population of 250 children, 250 aged, 50 to 100 in the hospital, plus the necessary personnel.

### Self-contained Institution

The power house is located at one of the lowest spots on the grounds but is in the center of the development where, within a few years, trees will almost entirely hide it from view. As this institution is some distance from any public utilities, it must necessarily be self-contained. Two 125 H.P. high pressure oil-burning boilers provide heat and water for all of the buildings and operate all machinery and the generators. An ice machine and central refrigerated store house, a seventy-five KW and a thirty-five KW direct current generator pressure water system, a laundry and rooms for a few of the male help are in-



Architect's drawing of ultimate development of the main hospital building of the Security Benefit Association, Topeka, Kans.



A view of the equipment in the x-ray room of the main hospital building.

cluded. Eventually it is expected that this will be the nucleus around which will be built central storerooms and repair shops.

The first building for the aged was completed in 1921. This may be considered a typical cottage, except in one or two respects. The inclusion of quarters for a superintendent on the first floor is only a temporary arrangement. The single bedroom, the large closet, the ample toilet and bath facilities, the large living and dining rooms bespeak a commendable consideration of the problems of the care of the aged.

Each cottage will have its own kitchen, thereby avoiding one of the most serious defects of most homes for the aged, the congregate dining rooms.

The third stage of development was the hospital building dedicated in January, 1925. To understand the plans thoroughly it may be well to restate the problem:

1. A hospital of 40 to 50 beds capable of expansion to 100 or 125 beds.
2. The patients would be limited to members of the Security Benefit Association.
3. Incidentally it would serve the children and old people resident on the grounds.
4. It must permit of the construction of a future memorial tower, the central architectural feature of the group.
5. It must be fireproof and complete in every way, without extravagances.

As the fraternity numbers among its members residents of every state the functions of this hospital are not

yet quite clear and will not be for a number of years. The association has about an equal number of men and women among its members. Will it become the Mayo Clinic of its members—a hospital to which the members resort when the local physicians are baffled either in treatment or diagnosis? That is the hope of the directors of the association and the answer lies with the medical personnel of the hospital. The board of directors ruled out all chronic, pulmonary tuberculous, obstetric, psychiatric, contagious and venereal disease cases. It was also recognized that the average length of stay would in all probability be longer than in the ordinary hospital and that provision must be made for a larger percentage of convalescents. As the field from which the hospital proposed to draw its cases was quite narrow it was decided that it would be wiser to avoid a training school for nurses and depend entirely upon graduate nurses for the first few years at least.

As the medical officer, resident at the building, would be in complete charge of all patients the usual staff would be largely eliminated. This medical officer would have a consulting staff but the demand for their services would be far less than in the usual community hospital. This affects the plan in many ways. The absence of large doctors' locker rooms, for instance is to be noted. While two operating rooms would be quite meager in a 100-bed community hospital, they will be quite sufficient here with only one operating surgeon. Any superintendent will readily grasp the simplification that would result throughout the hospital were the staff reduced to a chief medical officer,



assisted by consultants in each of the branches of medicine. Other differences will be noted in the description of the plans.

As there were no existing buildings and ample grounds were available the problems of future expansion were correspondingly simplified. But there was no precedent to assist in determining how fast or in what direction the hospital needs of this kind of a community would grow, if at all. Other questions enter into the discussion of the expansion. Might not the laboratory be called upon to make tests for a great many who were seeking admission? Would it be unreasonable for the society to encourage periodic examination of its members? If these steps were deemed necessary it would undoubtedly increase the laboratory work very measurably. Would it be to such an extent that more room would be necessary? If the physiotherapy department were used for the amelioration of conditions among the aged as well as among the hospital population would it be large enough? A hundred similar questions were considered.

#### Ultimate Development Plan

The plan adopted for the ultimate development is an inverted "U" with a short stem to the north housing kitchens and operating rooms. While the west wing of the completed group has been tentatively assigned to the nurses' dormitory and the east wing for hospital expansion, it has been recognized that this may be entirely changed by the results of a few years of operating experience. Increased service may require a rearrangement.

The following principles were established as a guide:

1. The second and third floor of central (initial) building would be used for acute cases.
2. The wings, if needed, would be used for convalecents and for nurses.
3. If expansion of laboratories and other auxiliaries of the hospital was needed prior to an increase in bed capacity the nurses' or the medical officers' quarters would provide the necessary space.

While no attempt will be made to explain the plans illustrating this article, a few comments seem desirable.

Around the central entrance on the south front are grouped those facilities that may be used by other inmates of the institution and by visitors—offices, reception room, x-ray room, physiotherapy department, laboratory, doctors' offices and elevator.

At the extreme left of the first floor is a three-room kitchenette apartment for the resident medical officer, and at the extreme right are the nurses' quarters to accommodate six, with living room and toilet facilities.

To the rear are the kitchen and dining rooms. Food may be sent up on the dumb-waiters or by carts on the elevator which has a door opening directly into the kitchen.

The front portion of the second and third floors are almost identical, each equipped to care for about twenty patients with a six-bed room on each floor and the balance in two-bed and single bedrooms. As all patients are entitled to exactly the same privileges and all beds are free beds, assignments will be dictated by the medical needs of the patients. Utility rooms, nurses' station and other auxil-



Portion of the six-bed ward in the west wing of the main hospital building.

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X-Ray Department  
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## Eminently Practical

Because of its acknowledged leadership physicians and engineers who have devised improvements in X-Ray apparatus automatically submit their ideas to the Victor organization first.

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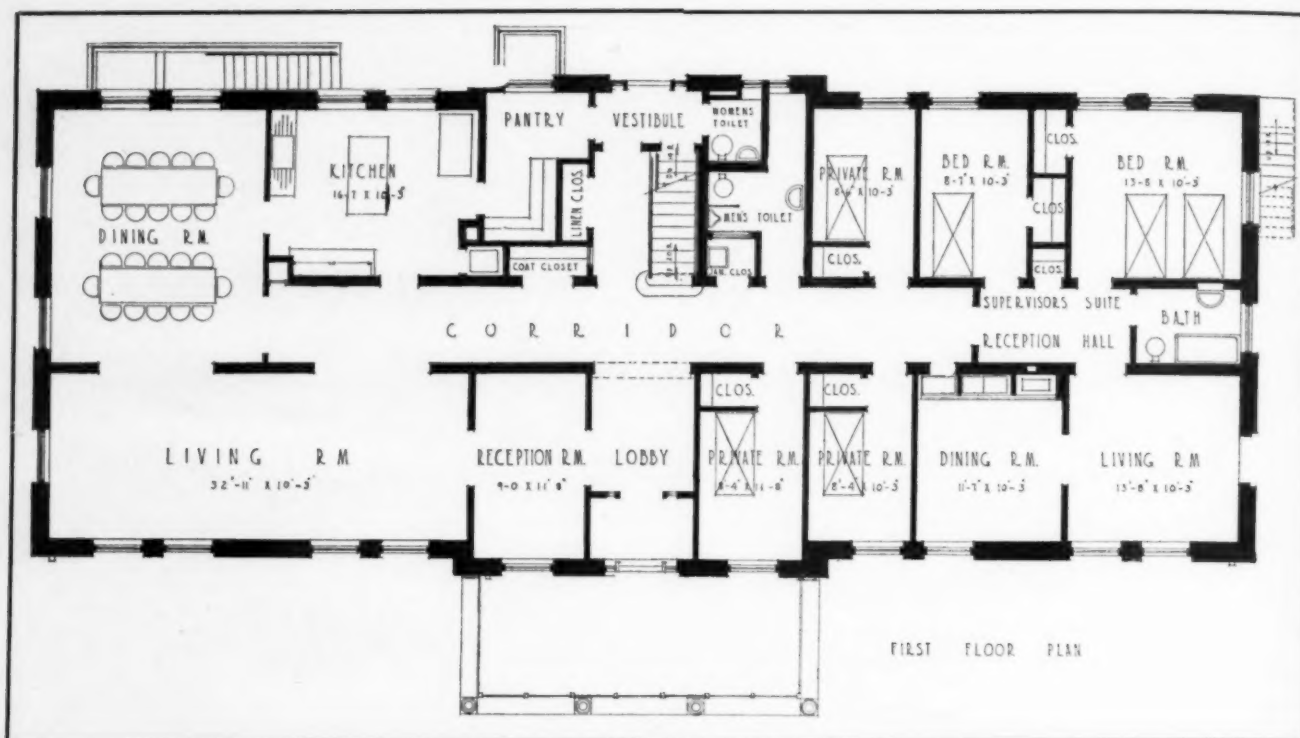


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First floor plan of the initial building for the aged.

aries are centrally and conveniently located. Food service trays set up in the kitchen on the first floor will be either by dumb-waiter or elevator to the floors. Dining rooms on each floor are provided for convalescents. As their number could not be definitely determined these are so arranged that they may be used for patients at any

time. All central food service features are provided.

The surgical department (second floor north wing) is rather smaller than one would expect in a community hospital of this size, especially so in the service rooms. The reasons have been explained above. The absence of an obstetric department has also been explained. Provision



Second floor plan of the main hospital building.

## Something for the Hospital Buyer to Remember

There is as much difference in the quality of gelatine as there is in butter.

We could take a cheap, acid-containing gelatine; beautify it with artificial coloring; neutralize the odor and flavor with so-called fruit flavors; load it with 80% sugar, and sell it for less than the producing cost of Knox Sparkling Gelatine.

But it would not be so economical for the user as Knox Sparkling Gelatine, because it would go only one-fourth as far, and we could not recommend it for therapeutic requirements.

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*Free from harmful  
acidity, artificial  
coloring, and syn-  
thetic flavoring.*



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View of the main kitchen, showing the efficient layout.

for isolation is made in the north wing of the first floor.

The proportion of men and women among the probable patients was another uncertainty. It seemed unwise to provide complete toilets and baths on both floors (containing only twenty beds) for each sex. Nor was it wise to assume that the sexes would be equally divided and assign floors to each. The plans permit of the utmost flexibility, that is, two sets of toilets are provided on the third floor and one set on the second.

In its interior finish the hospital is so unusually well done that there are few hospitals of its size that are comparable to it. The watchwords throughout have been economy of maintenance and operation, comfort of the patient and the convenience of the physicians, nurses and help. Just to catalogue a few of the details the following specifications are listed:

1. Floors of terrazzo throughout except in the basement where they are of concrete
2. Mop boards of terrazzo at a forty-five degree angle to prevent striking the walls
3. Marble window stools
4. Silent nurses' call system
5. Bracketed electric lights in single and two-bed rooms
6. Sound absorptive material in the corridor ceiling
7. Mat green tile wainscoting in the operating rooms and glazed tile in utility and sterilizing rooms, and kitchen
8. Push button elevator
9. Solariums on each floor

With the completion of an extensive landscaping program now under way the barrenness of the buildings, so evident from the illustrations, will begin to disappear. As future buildings are constructed, the group will assume a coherence and unity not now evident in the out-

lines of the plan with only a few buildings sketched in, and the roads with the trees and shrubs still in the sapling stage.

The exterior is of a local wire cut brick, ranging in color from browns and purples to pink relieved by gleaming Carthage marble and topped by a variegated slate roof. The future memorial tower and the entire group is a very free adaptation of Independence Hall, both in material and in composition.

#### PATIENTS SEND HOLIDAY GREETINGS

It requires little imagination for hospital superintendents to realize the aching loneliness that must come to their patients on such days as Christmas, New Year's Day, Mother's Day, Decoration Day, Thanksgiving Day and other days of national importance.

One superintendent did much to alleviate the pangs of loneliness for his many patients when he ordered a large assortment of attractive cards engraved with the name of the hospital. Several days in advance of each holiday he has the nurses show the cards to all patients and offer to mail as many as they wish—up to twenty-five—to friends and relatives. This procedure served the double purpose of keeping the patients' thoughts active and away from their own troubles, and of causing favorable comment from friends and relatives throughout the vicinity.

Life is a hospital in which every patient is possessed by the desire to change his bed. One would prefer to suffer near the fire, and another is certain that he would get well if he were by the window.

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## NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, M. A.,  
Butler Hall, 402 West 119th Street  
New York

### THE INTERRELATION OF THE LAITY WITH NURSES

By Mrs. John H. Lowman, Member of the Trustees' Advisory Committee, School of Nursing,  
Western Reserve University,  
Cleveland

**N**URSING is influenced at a very large number of points by the acts and opinions of the so-called laity, for we must define laity in this instance as meaning all those who have no special knowledge concerning the care of the sick.

In the first place, it is the lay people who have to be nursed, therefore their needs will eventually control the situation because of the intimate interworking of supply and demand. However, it takes a long time in a highly complex civilization for any law to find a natural solution, and most happily the growth of knowledge of the aims and tendencies of nursing induces an increasingly large number of persons to cooperate with the leaders of the profession and to secure for its members a wider, and at the same time, more complete utilization of its power for good.

In the meantime, nursing, like every other human avocation, must encounter the dangers and fallacies of the period in which it finds itself, and to a certain extent will not remain unscathed by the mass influences of its time. For instance, in an age of intense devotion to the Golden Calf it is impossible that an entire generation of nurses should stream by the idol without making at least an obeisance; but one who knows nurses well will say with conviction that the spirit of gain is by no means the dominating spirit of the profession.

#### Where Are the Points of Contact?

However, this is slightly aside from the question we set out to discuss. What we really wish to consider is, at what points do lay people and nurses meet in an opportunity to prosper the interests of both and of society. These points of contact are much more numerous than any of us suppose and are by no means necessarily personal.

From the first step that a young girl takes away from the protection of her home, to the time when she issues from a hospital school as a graduate, she can be said to be, indirectly at least, largely in the hands of the laity. And what the various lay persons who help convoy her steps know or do not know regarding the path they have oftener than not urged her to follow, has the greatest influence upon all subsequent developments of her education and usefulness.

In spite of all that has been written and said on the subject of nursing, many persons are still unaware that

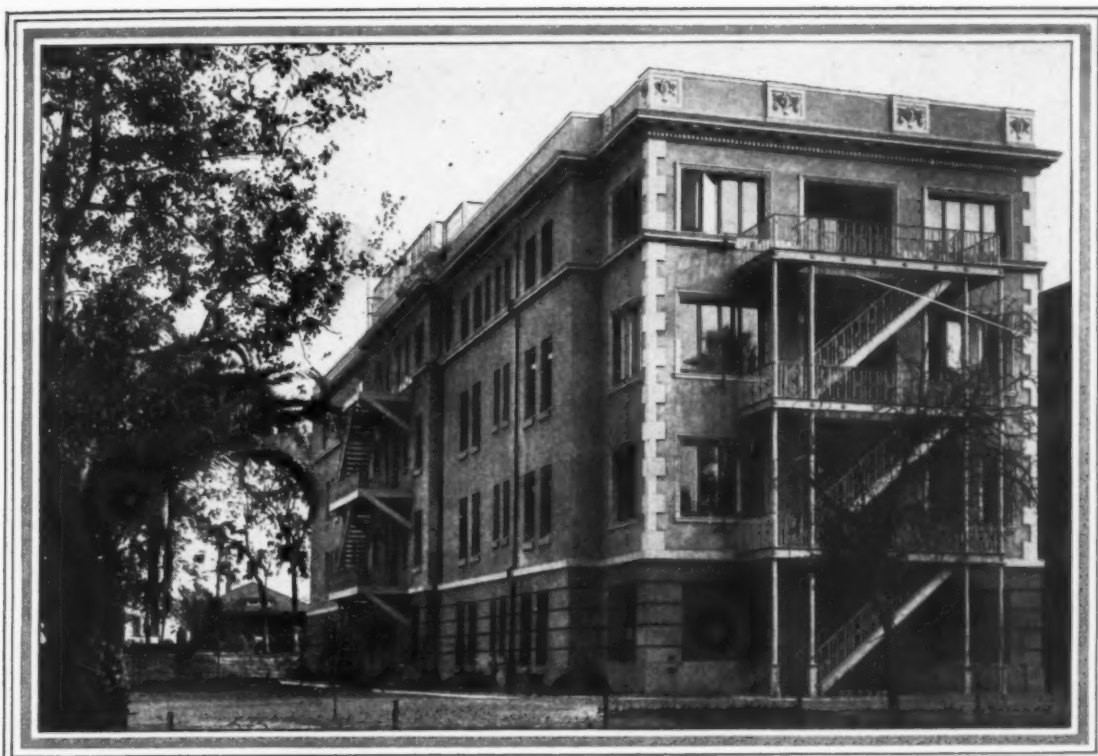
hospital training schools began on account of a need on the part of hospitals to have a personnel who would give nursing care to the sick at a figure that their treasury could meet. They took inexperienced persons who had had no previous contact with the sick and taught them, under some direction, to take care of their patients. The exchange of maintenance, training and a small gratuity for service was all that hospitals originally afforded.

It seems to have been frequently necessary to go and persuade young women to enter these institutions, as well as to overcome the serious objections of their parents. Lay persons have largely made themselves responsible for recruiting these candidates for hospital training schools, and the people who have undertaken thus to influence the lives of young persons in the choice of a vocation have been, until recently, animated almost solely by the immediate end of helping some hospital to meet its obligation to care for its sick at an expense which it could afford.

#### Influence of Laity Noted

The thought of the kind of training which the young woman herself was to secure, or of her value after she had finished her apprenticeship, was quite honestly and very innocently neglected. And here we must say that in the beginning these lay people had a far-reaching influence upon nursing, because, depending upon whether they simply knew that such and such a hospital needed more caretakers for its sick, or whether added to this knowledge was the knowledge that some training schools were better fitted to prepare the nursing candidate than others, the young person came in for a fairly good chance in life or a very poor one.

The next group of lay people who exercised an influence over the destiny of the nurse were the persons managing the hospital treasury and those who, together with the principal, mapped out what these young women were to receive at the hands of the hospital in addition to maintenance and a small gratuity. And here, of course, the beneficial as well as detrimental influences of competition entered the field. For the amazing growth of such institutions and the reluctance of young persons to enter them, led to many kinds of competition in the effort to procure the so-called student nurse; and among these efforts, of course, was that of introducing better conditions as to housing, food and hours, and the introduction



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constantly to keep abreast of the latest hospital needs and to give its hospital customers the same high degree of efficient service that doctors and nurses devote to their patients.

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of a measure of theoretical instruction into the curriculum.

Of course, I am now speaking of an earlier day and I am saying nothing of the continual efforts of the leaders—missionaries, I might say—in nursing, to put training schools into a place where they could justly be called schools of nursing. The reason I do not speak of the lifelong efforts of these nurses is because I want to keep to the subject of the influence of the laity in the development of nursing.

What lay persons have failed in great measure to recognize is that, in a practical sense, the better the product that enters the school, the better the immediate care of the sick and the ultimate value to society at large. What the lay person has responded to with the greatest enthusiasm has been the need for more hospitals, more buildings, more brick and mortar and more appliances, without setting emphasis enough on the quality of those who were to help care for the sick in these institutions. Nursing has been too often an emergency proposition in the mind of the lay groups who have financed the enormous expansion of the hospitalization of the sick in this country, and, as in many other instances, we have hardly had time to inform ourselves, so fast have we had to travel over the road. At times it seems almost as though some calmer nation than our own ought to watch over our destinies and prepare in quietness a sublimation of essential truths which we might read while running.

#### Confusion of Issues Is Baffling

However, if on one hand the lay influence has often helped to work an injustice in the matter of the education of nurses, lay people have also helped to make possible for nursing its present day development and standing, just as they have bolstered and strengthened and buttressed at every point the needs of medical research and medicine. The earnest lay people in the United States are so eager to help, so strong in numbers and so well meaning that it is only necessary for them to become firmly fixed in the belief that a certain plan is a true solution of a need to give it their devoted allegiance. But the subject of nursing has been so inextricably intermixed with the immediate needs of the sick for bedside care and the lack of funds with which to provide trained care for them, that there has been a confusion of issues and appearances that has baffled the most willing layman.

A hospital, we will say, had more patients than it could engage trained people to care for, therefore it diluted the trained personnel with a sufficient number of inexperienced people to lighten the financial burden. These inexperienced people were supposed to learn through doing—a very excellent way to learn, if present doing is intelligently supervised and related to future doing as well. But, of course, this cannot be achieved unless instruction accompanies supervision and unless the subject for such instruction is intelligent and receptive. All of this is now A B C to people concerned with good hospitals, but it was very far from being A B C twenty years ago, we will say, and even today there are hundreds of hospitals in this country that are where most hospitals were two or three decades since. And this is why a much greater burden of responsibility for the question should rest upon a well informed lay public.

The evolution of the care of the sick and their needs is not in any sense at cross purposes with the thorough education of the nurse, if we will but acknowledge where the apparent conflict lies. Is it not that the hospital is primarily a place in which to care for the sick, and secondarily only a place for educating those who must help

in the care of the sick? These are its main functions.

The need of the hospital is pitched in the present tense, and an emergency present at that. The need for the careful preparation of the nurse in the care of the sick has to do with her entire career of usefulness and success. On the horns of this dilemma the sick in hospitals must in either case be to some extent the losers, although only from the ideal point of view, because were it not for hospitals they might have little or no care at all.

Eventually this whole matter will be worked out largely by mixed lay and professional groups; but the lay groups will always have a great deal to do with the ultimate decision, because education is an expensive thing and the cost of better education will have to be subsidized by lay persons from private means, or by taxpayers from the common purse. And the more the lay person knows about the whole question, the higher will be the return to society for the money spent.

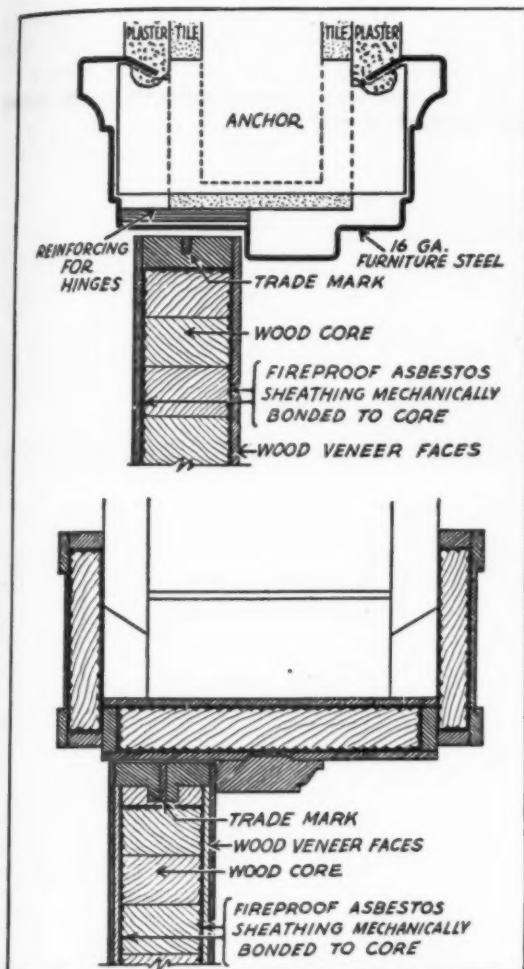
Here we can see in evolution the subject of the nurses' training in hospital schools. Sixty years ago there were, practically speaking, in the Protestant world at least, almshouses rather than hospitals, with utterly untrained, uneducated attendants employed for the care of the sick, under the minimum of medical supervision and with no thought of a future usefulness for the attendant elsewhere. These attendants, even then, were interspersed with missionary nurses who were women of education, culture and refinement, who undertook the care of the sick from religious and humanitarian motives.

The next phase of evolution concerned itself with more hospitalization of the sick, and with the introduction of a school system in the hospital for teaching as well as training nurses. But beginning with 1890 or thereabouts, the increase in the number of hospitals became so rapid that this school idea was exploited in all kinds of ways, according to the degree of ethical understanding of the persons who supported and managed the hospitals. Of theoretical teaching in any real sense, there could be but little. However, little as it was, it had to suffice, for there was little other to be had. The need of the hospitals was immediate; they had need of willing hands and feet for service concerned with present occupants of hospital beds. This system, its many faults notwithstanding, turned out many excellent bedside nurses and answered the needs of the more simple practice of medicine and surgery of that day and time, though for a country that has a tendency to rush headlong into the future it cannot be said to have been foreseeing.

#### More Theory—Less Practice

With the tremendous evolution of medical and surgical procedure and technique, the apprenticeship plan of training for nurses could not be made to fit, and in the process of reorganizing hospital schools to give a better education, the whole question has become seriously complicated; because, what with the introduction of more theory into the nurse's work, she has become apparently less available for the bedside care of the sick, and in an effort to train her so that she can safely carry out the directions of much more complex medical procedures, physicians, nurses and laity alike have become confused by the difficulties involved in the whole problem. I dwell upon this particularly, because I believe that the lay public will, eventually, recognize the fact that the hospital is a place where little besides the supervised bedside care of the sick can be given as its contribution toward a nurse's education, unless the sick, the physicians and the education of the nurse herself are to suffer thereby.

There is yet another way in which the lay public greatly



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influences nursing. Take, for example, the industrial towns of our own state of Ohio, and you will find that the presence of great industries always draws a large population of workmen, and that these laborers suffer from various accidents and illnesses peculiar to their occupation. As a result, great hospitals spring up in the neighborhood of these plants and numbers of young women come into such hospitals to learn how to care for the sick.

In many of these hospitals little besides surgery is done, and of course, student nurses cannot get a rounded training by working in such institutions only. Naturally if one could guarantee that they would never go out of these particular institutions to nurse elsewhere, or even that they would bind themselves to nurse surgical cases only, their training might seem adequate. But life cannot be depended upon to work in that way. You cannot imagine a young person engaging herself never to do general nursing just because her experience has been limited to surgical nursing. So it has been found wise to send nurses from hospital to hospital where they can take care of patients sick with a variety of diseases. But here again I am straying from the subject of the lay influence on nursing.

The lay influence in these big industrial towns comes about through the creation of great industries, and the fine hospitals to meet the needs of a population of employees and their families and other persons whom the suction of a big energetic town always draws to itself. In these places where energy and capital are at work you will find hundreds of nurses, not only in hospitals but in nurses' registries. A drive of a hundred miles or less into a rural district will find the country almost without medical or nursing care. The lay people in these counties are not numerous or powerful enough to build hospitals or to attract adequate medical and nursing care; and for these counties the state should provide in some way.

State universities could well have schools of nursing exactly as they provide trained people for other occupations, and some of these nurses could be trained especially for rural work. The metals and forests, the grains and live stock of a state are not as important as the health of its human beings. Most fortunately nurses, physicians and lay people are wrestling with and prevailing over this problem too, and when their vision and purpose become clear and steadfast it will translate itself into some general system of action through our state universities and other institutions.

#### Better Organization Needed

Yet another way in which the lay public influences nursing is by the kind of demands it makes upon nurses. During the war, nursing as a luxury was forbidden. It was used as a necessity—at most as a comfort, and not at all in a spirit of self-indulgence.

One instance which made a decided impression upon me is the following:

In 1918 a physician asked a graduate nurse to go to the house of a patient of his to care for a sprain which required two treatments a day, one in the morning, and one in the evening. The nurse replied that she was under an obligation not to take work of a kind that could be performed by a visiting service. She had been in a sense drafted for continuous duty. He acknowledged the wisdom of such an arrangement, and honored her for respecting it.

Fine nursing is an art that should be exercised for the greatest number who need it—not for the half use of the few who can pay for it by the day. It is a pity that we find ourselves so much more capable of self-sacrifice during war times than in times of peace.

If graduate nurses were to make their services available to greater numbers through better organization I believe the result would be greater sympathy on all sides.

I have left to the last the relationship in which lay people have worked together and have achieved perhaps the greatest amount of interpenetration of effort, and that is in what we call public health nursing.

In the initiation and development of a form of service that has affected so many and such profound changes in the care of the sick and the prevention of disease, the nurse and lay person have worked hand in hand and heart to heart for something over twenty-five years in this country. In fact it was through the portals of this kind of nursing interest that one of our Cleveland citizens, after devoting herself mind and purse alike to the support of community nursing during the fateful years of the World War, has since made a money contribution to nursing education greater than any single contribution that has ever been made anywhere at any time. Indeed so much larger, that we have a chance here to work out in our own Western Reserve University a plan for the education of nurses which, unhampered by the hitherto constant elements of anxiety and compromise, will, we hope, enable all concerned to see the problem steadily, and work it out thoroughly and sensibly.

However, even in the use of this privately bestowed fund, public opinion will have its part.

#### Should the Nurse Pay for Training?

To turn to a somewhat different phase of the subject. There are lay people who ask why the nurse in the hospital school should not pay for her education as the teacher pays for hers. To this I would answer that there has never been any system devised by which she could pay for it except by working her way through. We have not yet thought of nursing as a public service in the sense that we think of our Army and Navy as public services; and yet our legislatures are constantly introducing new laws whose operation will largely depend on the cooperation of well educated nurses and the nurse is the only woman who is expected to serve officially in war. The success of the whole public health movement also depends in a large degree on the nurses' availability and understanding. No man feels belittled at accepting his education at the hands of his Government at West Point or Annapolis. But, of course, in the case of these schools the competition for entrance is very keen, because the entrance requirements are high and the accepted candidates few in number.

Other lay persons have said to me, "If the education of the nurse must be subsidized, why should not medical education be subsidized also?" To which one replies, that it is very greatly subsidized. Its place is recognized in our state universities; enormous gifts and bequests are constantly poured into the treasury of medical education. Hospitals complete the training of their medical interns; and as for the general universities in which they receive their education, they have been so heavily endowed, and are constantly the recipients of such gifts, that it is impossible for any student, no matter what the state of his purse, to pay more than a part of his expense in any institution of high standing. Gifts to nursing education have been few and far between, simply because the public as a whole has as yet hardly realized that there is need for such a thing.

We cannot get away from the fact that a well informed public opinion is the greatest treasure that any community can possess. Depending upon whether lay opinion or lay prejudice prevails in a community, it will have useful, or

(Continued on page 476)

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and by ALEC N. THOMSON, M.D., Medical Secretary, Committee on Dispensary Development, United Hospital Fund of New York 15 W. 43rd Street, New York

### BETTER BABIES FOR NORFOLK

By Blanche F. Webb, R.N., Director, Visiting Nurse Service and Children's Clinic of the King's Daughters, Norfolk, Va.

"THE best clinical work I ever did in my life was during the summer we organized the babies' clinic," said Doctor Royster of Norfolk, Va., in describing the development of the Children's Clinic there.

The clinic was started twelve years ago, in a single basement room with the services of one doctor and one nurse. Today, there are a three-story clinic building; a visiting staff of twenty physicians; an infant welfare supervisor, with three other nurses working under her; a clinic nurse; a social service nurse and a dentist paid by the city, who has office hours five afternoons a week. Other special workers also come in, such as the laboratory technician who is on duty every Monday and Friday.

The establishment and growth of this welfare organization is an unusual example of cooperation between physicians, a nursing service and lay groups. Eighteen years earlier a small band of women called "The King's Daughters" brought to Norfolk the first district nurse. She was

not only the first visiting nurse in Norfolk but in the whole state of Virginia. The doctors welcomed her services and found so much for her to do that other nurses were soon needed. To support them, more circles were formed in all sections of the city. This meant an increasing number of women working for and interested in the Visiting Nurse Service. Thus the four circles of 1896, with a membership of about fifty, have increased by 1926 to twenty-five circles with a membership of over eight hundred.

It was natural, then, that these nurses, constantly confronted by the needs of the babies and children in the districts in which they were working, should turn to the physicians to help them to meet these needs. The situation seemed particularly acute in the summer of 1914 when the mortality from summer diarrhea among infants was very great. Ethel Smith, the superintendent of the King's Daughters Visiting Nurse Service at that time, enlisted the services of Doctor Royster. He agreed to hold a clinic three afternoons a week, provided that Miss Smith would assign one of the visiting nurses to follow up his cases. Over one hundred and fifty babies were cared for, most of them seriously ill. Out of this number only four died.

#### Three Clinics Held Weekly

Doctor Royster and Miss Smith had opened the clinic as a temporary summer measure and intended to close it during the winter. But the mothers whose children had been brought back to health through the services of the clinic, so strongly desired to keep them under its care, that it was continued. As a matter of fact, Doctor Royster acted as chief of staff for ten years.

Attendance grew so rapidly that Doctor Royster soon needed another physician to assist him and the King's Daughters, who had moved into larger quarters, remodeled the whole basement for the use of the clinic. At the end of five years the yearly attendance was well over four thousand, and would have been greater had there been room to take care of additional patients. Not only babies, but children up to fourteen years of age were also admitted.

The Kiwanis Club of Norfolk recognized the value of this work and built a large and modern clinic building. This building at first was only two stories high but by 1924 clinic attendance had reached a total of over nine



Some babies look like this when they first come in.



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Mothers and babies leaving the clinic.

thousand and a third floor became necessary. This also was donated by the Kiwanis Club.

On the lower floor there are ten examining rooms; on the second floor a laboratory, a rest room, and the dental room. A small operating room, a ward containing six beds and a nursery, with eight beds for babies who are ill, occupy the third floor.

Clinic sessions are held three times a week—Mondays, Wednesdays and Fridays. The doors are opened at one o'clock and patients are admitted until two when the physicians arrive. This plan gives time for temperatures to be taken, charts to be made out and patients prepared. Wassermann tests are made on all children and mothers. A urinalysis is taken for every child with a temperature. Each child is given a complete physical examination and, when necessary, referred to a specialist. Babies under eighteen months of age are assigned to the feeding clinic. Over eight hundred are under its supervision at the present time.

Frequently babies are kept in the nursery for several weeks. They are brought to the clinic sometimes so ill that it does not seem possible that they can live through the night. Undoubtedly many lives are saved because the clinic is able to take in these babies and look after them. The director of public welfare in Norfolk is proud of the reduction in infant mortality there during the last few years, and he attributes it in large part to the work done in the clinic and in the home by the visiting nurses.

The following figures are significant: In 1918 there were 138 deaths of infants under one year of age for every thousand living births; in 1925 there were only eighty.

This, however, is but one phase of the work. For the benefit of children less critically ill, genito-urinary, skin, eye, throat and ear specialists hold regular weekly ses-



The school nurse arrives.

sions, and once a month there is an orthopedic clinic.

Minor operations, such as for adenoids, tonsils, and circumcisions are performed in the small operating room. Coagulation tests are made on all such cases and after the operation the patients are kept for twenty-four hours in the small ward. After their return home, they are under the supervision of the visiting nurses.

The aim of the clinic is to do thorough work. Its steady growth, and the interest shown and support given by the townspeople, indicate its value to the community as a whole.

### PLANNING THE IDEAL HEALTH SERVICE FOR THE COMMUNITY

The exact plan of local health service that will fulfill all the essential requirements of any selected community must be adapted to the circumstances and conditions peculiar to that community. Because of climatic, geographic, political, social, racial, economic or other purely local characteristics, the vital health problems of one city may well differ from the particular problems that are of special concern to some other city. This idea has led at times to the conclusion that it is impracticable to propose any standard or uniform basis for health department organization.

As a matter of fact, however, many of the obstacles to be overcome in developing an adequate and comprehensive plan for community health service are imaginary rather than real ones. Man is subject to certain diseases and disturbances that obey rather fixed laws, irrespective of purely local conditions.

In spite of such considerations, the essential public health problems in different cities differ not so much in their nature as in the comparative magnitude of the problems presented. There are certain basic requirements that should be fulfilled in practically every community so that it is possible, therefore, to propose a more or less "ideal" health service that will at least represent minimum requirements.

In the report on the surveys of 1920, prepared by the American Public Health Association, there was presented a plan for an "ideal" health department for a city of 100,000 population. This plan represented, in the opinion of the authors, the best current practice in each special line of activity, based on the average practice in the eighty-three large cities, or on the practice of cities which appeared to excel in some particular activity. The details of this proposed minimum standard for the larger cities were clearly set forth.

In the recently published report on the survey of the eighty-six smaller cities by the American Child Health Association there is included a somewhat similar plan of organization for a city of 50,000 population. In both of these plans the same essential items of service are included, and the scheme of organization for the central health department is on a somewhat similar plan.—*Public Health Reports*.

At the ceremony attending the opening of the Hospital of St. Clothilde in Flanders in 1362, at which 30,000 people were assembled, a collection was taken up to help support the hospital, and an amount exceeding \$10,000 was subscribed. This founded a permanent fund to take care of women who were unable to support themselves during the period immediately following childbirth, and were dependent upon charity for their maintenance.

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## DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES, 7 East 54th Street, New York  
and MARY A. FOLEY, Director of Dietetics, Kahler Hospital, Rochester, Minn.

### IS INSTINCT A GUIDE TO FOOD?\*

*"It is one of the axioms of physiology that the majority of the diseases of mankind are due to, or connected with, perversions of nutrition."—Professor R. H. Chittenden.*

THE philosopher, the psychologist and the biologist dabble with the nature of instinct. Often enough the word is used by them as vaguely as the phrase "chemical affinity" is used by the chemist. Why do oxygen and hydrogen combine? asks the student. Because there exists a chemical affinity between them, answers the instructor; a matter of electronic distribution. What, then, causes a bird to come out from its egg and later to build its first nest? Instinct is the ready response. The questioner, revolving the matter in his mind, may think of instinct as synonymous with intuition, with impulse, with spontaneity. He will be partly right, and yet not altogether so.

Instinct has been defined as "a propensity that urges an animal or human being, without exercise of reason, to the performance of actions which are for the most part normally useful or beneficial." We have selected this definition in preference to dozens of others, not because it is so much better, but because it expresses the meaning of the word as we shall use it in this article. The definition emphasizes the complete divorce between instinct and intelligence and points out that instinctive actions are, "for the most part," but *not invariably*, useful or beneficial.

#### Instinct Processes Complicated

The physiological and psychological processes involved in instinct are many and complicated. The more obvious sequence of events that may be noticed in an instinctive action are, first, that the mind is excited by the object; secondly, that the mind becomes "activated," or mental processes arise, as a result of contact with the object; and thirdly, that there is action that has direct reference to the object. The suckling of young animals; the pecking of young chickens; nest building; the migration of birds; the honeycomb-making of bees; egg deposition by moths and butterflies, and the selection of food by all sorts of animals have been cited as typical examples of actions involving instinct.

We must now narrow our horizon to limit ourselves to the play of instinct in the selection of food. What first gives rise to the desire for food? Obviously enough it is the sensation of hunger—the fundamental motive to individual self-preservation. Professor Cannon of Har-

vard and Professor A. J. Carlson of the University of Chicago have shown that this is purely a physiological phenomenon and is due to the muscular contraction of the walls of the stomach. We seek to still these pangs, and it is at this point that what we may call instinct comes into play, for the food that we select, often without knowing why we select it, not only stops the contractions of the stomach, but is usually well utilized by the body subsequently to repair waste tissue and supply energy.

#### Are Hunger and Appetite Related?

Various writers have linked the sensation of appetite with that of hunger, and at times some have used the words appetite and instinct interchangeably. There seems to be reason for believing, however, that hunger and appetite are not different degrees of the same sensation at all, but really fundamentally different. "Appetite," writes Professor Cannon, "is related to previous sensations of the taste and smell of food; it has therefore, as Pawlow, the great Russian physiologist, has shown, important psychic elements. It may exist apart from hunger, as, for example, when we eat delectable dainties merely to please the palate. Sensory associations, delightful or disgusting, determine the appetite for any edible substance, and either memory or present stimulation can thus arouse desire or dislike for food.

"Hunger, on the other hand, is a dull ache or gnawing sensation referred to the lower mid-chest region. It is the organism's first strong demand for nutriment, and, if not satisfied, it is likely to grow into a highly uncomfortable pang, less definitely localized as it becomes more intense. It may exist apart from appetite, as, for example, when hunger forces the taking of food not only distasteful but even nauseating."

Between instinct and appetite there are thus differences and similarities. Instinct is the precursor which may lead to a development of appetite, but appetite is related to previous sensations (of taste and smell of food), whereas instinct assumes no previous experience of any kind. If we must set up connecting links, we might say that, under certain conditions, instinct is the go-between bridging hunger and appetite. It was instinct that led Bo-bo, the hero of Lamb's dissertation upon roast pig, to feel the pig. When he had burnt his hands and licked them, the dawn of appetite appeared. Once it is aroused, once the mouth is made to water—not a figurative but a literal description of what actually takes place—the rest may be explained in terms of orthodox physiology. For, as Pawlow has shown, appetite stimulates the flow of digestive juices, without which no food can be digested.

Incidentally, one of Pawlow's experiments bears upon

\*By Benjamin Harrow and Casimir Funk, published in the American Mercury, volume 4, number 16.



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the question whether appetite (and probably instinct) always manifests itself to benefit the individual. Once, when experimenting on a dog, he divided the animal's gullet in the neck and brought the two ends to the skin. Food taken in by the mouth thus passed down part of the gullet and then out into the open, without ever entering the stomach. But even under these conditions of sham feeding, with the hungry animal never really getting the food it needed and wanted, there was an abundant flow of gastric juice in its stomach, provided no nerves were cut. The sight of the food and its taste in the mouth were enough to set up reactions in the dog's brain which gave rise to the flow of stomach juice, despite the fact that it was of no value to the animal.

### Diets of Man and Monkey

If we trace the history of man back to the remotest time, when he was not exactly man, or monkey, or lemur, but some queer combination of all three, we may assume his diet to have been not very different from the diet of the monkey of our own day. The lemur-monkey-man probably lived largely on fruits and nuts, perhaps also on oysters and other shellfish, a little on insects, and occasionally on a bird or two. Hunger started him on his path of adventure and instinct guided him in his search. Occasionally instinct, not wholly perfect, would lead him astray, and then misfortune would befall him. This would prove an instructive lesson to others of his tribe, and for them thereafter instinct would be guided by experience. Here we witness the dawn of intelligence.

The diet of the lemur-monkey-man was passed on from generation to generation, and there is no reason to suppose that even during the fourth and last glacial period, when the Neanderthal man flourished—a matter of some 50,000 years ago—had his food changed considerably. So long as weapons were few, so long as fire was unknown, so long as the raising of cattle and the tilling of the soil were not practiced, man belonged to the hunted animals, and his food could hardly extend beyond the range of the monkey. The Reindeer man, flourishing between 35,000 and 15,000 years ago, developed the art of making implements, and during the Neolithic age, some 10,000 years back, certain animals began to be domesticated. The Neolithic man probably stumbled on the art of milking, and experience must have led him to use milk as food. A rude type of agriculture, the origin of which is a mystery, led to the cultivation of wheat and barley; oats and rye seem to have come much later. Animal foods, such as meats of various kinds, probably became common only when man had established himself as a keeper of sheep and a tiller of the soil.

### Instinct Guided Food Search

From now on, no radical changes in his diet are to be noticed. The people of biblical times, and many of the men and women who lived before the Industrial Revolution, ate much the same food, and even led much the same life that the Neolithic man did. Until quite within our own times, indeed, man lived on Nature's produce and was a healthy creature. Instinct had guided his remote ancestors in their search for food, and though with the progress of time, the intellect of man grew perhaps at the expense of his instinct, the former continued to urge him to eat what his forefathers had eaten.

But within the last hundred years or so, everything, our food included, has been revolutionized. Our foods are now "preserved, purified, polished, pickled, canned, extracted, distilled, concentrated, heated, dried, frozen, thawed, stored." How are we, particularly city people,

to select what is good for us? Our instinct is not what it was, and even if it had remained with us, it is doubtful whether, with a choice of food that is daily becoming more limited for many of us, and with a supply that undergoes so many chemical processes before we eat it, instinct would be a very reliable aid. What are we to do?

There is a considerable body of opinion, growing from day to day, that holds that our gastro-intestinal troubles—our stomach-aches, our headaches, our constipation, and so on—are largely the result of eating this artificially prepared food. Whatever instinct is left in us has not, if this thesis be correct, and the writers of this article are of the opinion that it is, guided us wisely in our choice of newly acquired foodstuffs. Our instinct should have warned us against the preserved, the pickled and the canned; on the contrary, it urged appetite to encourage us in selecting the preserved, the pickled and the canned—so much so, that our mouth now waters at the very name of delicatessen.

If we turn our attention to races who still live in the midst of primitive surroundings, where the artificial has not yet displaced the natural food, we may learn an instructive lesson. The Arabs, for example, live largely on figs, dates, some vegetables and a little milk. Meat is rarely eaten, and their religion forbids them to drink alcohol. Despite the undescribable filth in which they live, they are far more immune to disease than Europeans. "Diseases of nutrition," writes Dr. Auzimour, a French army surgeon, "are almost unknown; ulcers and cancer of the stomach are very seldom met with; and if one comes across a chance case of diarrhea, it is generally because the sufferer has been eating too many melons. Appendicitis is very rare among Arabs, and is entirely unknown among vegetarian nomads. Gout and kidney gravel are also quite unknown."

### Food Controls Disease Susceptibility

A fact that should arrest attention is that when these Arabs desert their dirty villages for the towns, and there live the life of Europeans, eating the food Europeans eat, they become as susceptible to disease as the latter. Their resistance therefore cannot be ascribed to the peculiarities of the race, or to the climate, but only to the food they eat.

Another, and equally instructive case is cited by Dr. McCarrison, an English physician stationed in India. "My own experience," he writes, "provides an example of a race unsurpassed in perfection of physique and in freedom from disease in general, whose sole food consists to this day of grains, vegetables and fruits, with a certain amount of milk and butter, and goats' meat only on feast days. I refer to the people of the State of Hunza, situated in the extreme northernmost point of India. So limited is the land available for cultivation that they keep little livestock other than goats, which browse on the hills, while the food supply is so restricted that the people, as a rule, do not even keep dogs. They have in addition to grains—wheat, barley and maize—an abundant crop of apricots. These they dry in the sun and use very largely as food."

Dr. McCarrison has spent nine years among these people. The men have a magnificent physique. They live to a very great age and are astoundingly fertile. This combination of fertility and longevity is, indeed, their one important source of worry. A humane chieftain suggested to the doctor that instead of bringing the sick back to health again, he concentrate his attention on the construction of a lethal chamber to get rid of those too old to be of use to the state. With another of these tribes, it was the custom, until quite recently, for the eldest

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son to put his two aged parents in a basket, carry them to the top of a hill, and then hurl them to death. Says Dr. McCarrison:

"During the period of my association with these people, I never saw a case of dyspepsia, of gastric or duodenal ulcer, of appendicitis, of mucous colitis (a disease involving that part of the intestine called the colon) or of cancer, although my operating list averaged 400 major operations a year. While I cannot aver that all these maladies are quite unknown, I have the strongest reason for the assertion that they were remarkably infrequent. The occasions on which my attention was directed to the abdominal viscera of these people were of the rarest. . . . Among them the abdomen oversensitive to nerve impressions, to fatigue, anxiety or cold was unknown. Their consciousness of the existence of this part of their anatomy was, as a rule, related solely to the sensation of hunger. Indeed, their buoyant abdominal health has, since my return to the West, provided a remarkable contrast with the dyspeptic and colonic lamentations of our highly civilized communities."

In searching for an explanation of this difference in health between Indians and Europeans, McCarrison has traced it to diet. "The people (of Hunza)," he says, "live on the unsophisticated foods of nature: milk, eggs, grains, fruits and vegetables. I don't suppose that one in every 10,000 of them has ever seen a tinned salmon, a chocolate or a patent infant food, or that as much sugar is imported to their country in a year as is used in a moderately sized hotel."

Like the Arabs, the Hunzas live in the midst of anything but sanitary surroundings, and like them again they contract gastro-intestinal disorders whenever they change to a more civilized diet. These facts are of the utmost importance, for they show clearly that despite unhygienic conditions, their unsophisticated diet keeps them free from the common ailments to which Europeans and Americans are subject. This, of course, is no argument in favor of filth; it is merely evidence that faulty diet may be an important causative factor in disease. Incidentally, it illustrates how faulty, or how latent, or how entirely absent instinct is in modern man.

#### Experiments With Wild Monkeys

Actual experiments with monkeys, carried out by Dr. McCarrison, give support to his views. Wild monkeys to the number of thirty-six were captured in the jungles of Madras and transported to the doctor's laboratory at Coonor. They were in perfect health and full vigor. Each of these animals was placed in a separate cage, and all were confined in the same animal room. One-third the number were fed natural foods (wheaten bread, milk, ground nuts, onions, butter, plantains and water), and the remainder on food deficient in any way or another; in some cases there was a deficiency of vitamins; in others, an ill-balanced diet was offered; in still others, the food was of the "natural" variety, but had first been sterilized. Says Dr. McCarrison:

"Those that were naturally fed remained free from intestinal disease; those that were fed on deficient and ill-balanced food, and on sterilized food developed, within a short time in the majority of cases, diarrhea or actual dysentery (a disease involving the inflammation of the large intestine). Here, then, is an unequivocal instance not only of the effect of faulty food in inducing a specific disease such as dysentery, but of the protection against it that is afforded by a natural and well-balanced diet."

Whether we take the view, as some psychologists do, that instinct has become "saturated" with intelligence, so that in highly civilized man it is now of little moment, or whether we agree with Metchnikoff that our instinctive actions have become perverted, largely owing to the consumption of alcohol, there seems to be general agreement that instinct in man is becoming less and less potent and

accurate. Our intellect, which has largely displaced it, cannot serve us as well in the selection of food; for though one of the characteristics of this intellect is that it builds on the accumulated experiences of the past, the food we eat today is vastly different from the food we ate in the past. Moreover, it seems plausible that the requirements, for example, of a New York City clerk and a Minnesota lumberman, will show degrees of difference. Scientific experimentation must therefore come to our aid. It must point the way towards determining the extent of harm done by the consumption of artificial foods. It must suggest such combinations of different foods as will provide for the varying needs of the organism. Given a limited supply—such as prevails in most of Europe, in all of Asia, and among the very poor elsewhere—how much of each type, and what combination of the various elements, will bring the maximum return to the human machine? Our instinct will not tell us; the food faddist misleads us; the politician and the legislator are ignorant. Our hope lies in the scientist of the laboratory, with his rats and mice and guinea-pigs, and in the dietitian and clinician at the bedside.

#### CANCER AND NUTRITION

Dr. Arthur Bliss Dayton, assistant dean of the Yale Medical School, reported during the month of December that Japanese researches into the causes of cancer have established a connection between cancer and nutrition. Scientists of the National Nutrition Institution of Japan have been able to produce cancer in rats by giving them foods deficient in Vitamin A. This is the second time that cancer has been produced experimentally in living organisms, and, according to Dr. Dayton, it will exert a vital influence on the study of the disease.—Harry W. Redfield, Ph.D., in the *American Journal of Public Health*.

#### FISH LIVER A VITAMIN RICH FOOD

In feeding canned livers from Lake Michigan fish to rats that have been maintained on a diet low in the anti-rachitic vitamin, it was found that the livers were high in their power to heal rickets, the burbot and whitefish livers ranking somewhat higher than trout liver. Chicken liver was also tried and found to have a high concentration of the anti-rachitic vitamin, while calf and beef liver was strikingly inferior in this respect.—*Wisconsin State Bulletin 373—1925*.

Miss Zettler, who has been dietitian at Jewish Memorial Hospital, Brooklyn, for several years, died March 7, after a two days' illness of pneumonia.

Sarah Morris and her assistant, Rose D. Barber, have resigned their positions as dietitians at the Hospital for Joint Diseases, New York.

Charlotte Addison, dietitian, Deaconess Hospital, Boston, and Sarah Merritt, dietitian, Grant Hospital, Columbus, Ohio, have resigned their positions.

Helen Skinner and Elsie Jo Nelson recently finished student dietitian training at the Mayo Clinic, Rochester, Minn., under Miss Mary A. Foley. Miss Skinner has been appointed assistant in medicine at the University of Illinois and Miss Nelson is dietitian at St. Elizabeth's Hospital, Chicago.

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## OCCUPATIONAL THERAPY AND REHABILITATION

Conducted by LOUIS J. HAAS, Director of Men's Therapeutic Occupations, Bloomingdale Hospital, White Plains, N. Y., and  
MRS. CARL HENRY DAVIS, Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.

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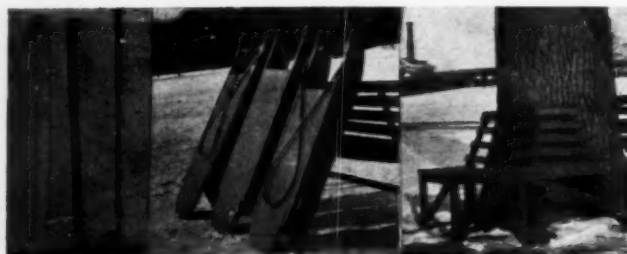
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Col. James A. Mattison, M. D., Soldiers' Home, Los Angeles  
County, Cal.

## CARPENTRY AS A CURATIVE OCCUPATION

By Josephine Walker, Supervisor of Recreation and Occupation, The Burke Foundation,  
White Plains, N. Y.

**T**HE wood work section of the occupational therapy department of the Burke Foundation, White Plains, N. Y., presents certain practical features applicable to convalescent and kindred institutions, such as preventoriums, camps, sanatoriums and hospitals for reconstruction.

With modest, basement shop space and simple equip-



A few of the articles made by men in the wood section.

ment, our men patients, who remain an average of less than three weeks, play no small part in the upkeep of the institution, and constantly aid in working out many new elements of simple construction.

As a prescribed therapy, the wood work and allied kinds of repair are well liked, and lead to desirable interest and ambition. This work is also adapted to the more seriously handicapped. Two-thirds of those assigned to this work have but little skill in this line, and yet under efficient guidance from the carpenters, cabinetmakers and others in the grouping, all may find suitable diversional and curative occupation. About fifteen out of the total 150 male patients are detailed to this branch. The house carpenter has some oversight of these shops, under the occupational supervisor, and frequently advises in new planning.

General repairs, which are, of course, so varied that they cannot be listed here, make up about three-fourths of this activity; but a judicious mixture of new work is kept before the patients, and the constructive feeling in this latter phase is important to the higher mental elements of the therapy.

Canes, so frequently required in this type of institution and usually so unsatisfactory, are now made inexpensively by patients, from boards one to one and one-quarter inch thick, varnished and fitted with rubber tip at bottom. Sleds, toboggans, skis, plain tables, checkers, croquet and

other games, settees, recliners and window seats, fences and other outside wooden parts—these indicate the scope of this formative work.

The toy-making shop is closely connected with the carpentry, and golf-shafting, pool table repair work, canvas work, window shade and screen upkeep, and patients' plain and decorative painting are partly under this section. Secondhand and waste box board lumber are largely utilized.

Neurological patients do particularly well in wood work. Adolescent boys, with crippled and older men and cardiacs, adapt themselves favorably to toy making and the lighter carpentry. Pride and interest in new construction develop rapidly in nearly all classes; inventiveness is encouraged. Appointed leaders learn to make inspections of the entire plant, report upon needed repairs and replacements, and offer suggestions for improvement.

The working period is one hour per day, but many wish to extend this, and plans are developed whereby certain of the more ambitious and needy may receive a modest wage for this extra formative effort. No vocational direction is assumed in this short term class, but in addition to the excellent tonic remedial effects, the majority become skillful in many minor ways that make them more efficient in their employments and in their homes.

### CALIFORNIAN OCCUPATIONAL THERAPISTS HEAR TALK BY BLIND WORKER

The regular monthly meeting of the California State Association of Occupational Therapy was held March 5 in San Francisco.

The first address was given by Kate Foley, teacher of the blind in association with the California State Library Department. Miss Foley is blind and for this reason brings much encouragement to her blind patients. In her work she teaches the patient not only to read but to type-write. She stressed the fact that in this work, as in all occupational therapy, the worker must be a lover of mankind and must have the strength to fill her patient with the desire to live and the determination to take up the thread of life where it was dropped.

The next address was given by Dr. Philip King Brown, one of the leading heart and kidney specialists of the country and a pioneer in occupational therapy in the state. He emphasized the part that occupational therapy plays in industrial accident cases. In dealing with such

## Maternity

The public is coming to realize that the hospital is the one safe place for childbirth, and the demand for maternity accommodations is quite generally ahead of the supply. If your hospital is planning an enlargement which includes additional maternity facilities, it is in an especially favorable position for a successful fund-raising campaign.

Our statements and our work are based on long experience in directing large and small hospital campaigns in villages and cities, in many states.



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cases, he said, the corporations themselves are having to provide new avenues of productivity for the handicapped. Dr. Brown feels that the time will come when occupational therapy and vocational training will be more closely allied and that the trained worker must be available in order to properly rehabilitate the injured.

Dr. Edward W. Twitchell, whose work with the neuropsychiatric is well known, spoke on "The Problem of Nursing and Occupational Therapy for the Nervous Case." Work as a cure for the mental case, especially dementia praecox was described. Cases were cited where the dementia praecox patient was restored to home and a normal life by being made to work constantly. The type of work depends on the individual case. The complexity of city life is too much for many nervous systems, according to Dr. Brown. The crowded office is no place for the neurasthenic girl. The inadaptability of many patients to city conditions proves the need of country and small town surroundings.

### WEAVING DEMONSTRATION AT FARM PRODUCTS SHOW

The annual State Farm Products Show was held in Harrisburg, Pa., recently. In connection with this meeting the department of health and the department of labor and industry held an exhibit. The department of welfare exhibited products of the Prison Labor Division; as well as products of the occupational therapy departments of state and county hospitals.

The farm show was unusually well attended. By actual count of the state police, over 80,000 people passed by the exhibits during the two heaviest days of the show. An estimate of a minimum of 100,000 is probably conservative for the full period of the show.

The occupational department displayed a variety of handwork and made a special weaving demonstration. Mrs. Acheson, chief of the occupational therapy department, Harrisburg State Hospital, operated a pattern loom. The public school children were particularly interested in the loom. There were also many interesting contacts made with farmers and their wives who were delighted to see the revival of the hand weaving.

The Farm Products Show gave a fine opportunity for discussion of mental hygiene aims and made known to many people the real purposes back of the occupational therapy organizations in the hospitals of their home communities.

### BOSTON SCHOOL CHANGES ITS COURSE OF TRAINING

The Boston School of Occupational Therapy takes pleasure in announcing important changes and improvements in its course of training for occupational therapists to take effect with the opening of the next class in September 1926.

Six months will be added to the present twelve months curriculum, making the total course cover eighteen months.

Because of the increasing demands being made upon graduate occupational therapists the need for additional hospital experience during training has been keenly felt and now that this has been arranged for, special emphasis will be laid upon extended experience in the field of mental work.

A close affiliation between the Massachusetts institutions under the department of mental diseases is being brought about and splendid cooperation is also being given the school by several of the leading hospitals in and near

Boston. It is planned that during at least six months of a student's hospital training she will be allowed to live in the hospital and receive full maintenance.

The need for fully trained, well qualified occupational therapists throughout the United States is much greater than the supply and for any young woman interested in hospital work there is no greater or more inspiring field of service.

At a recent meeting of the directors Dr. John D. Adams was elected president and Dr. Joseph Pratt, vice-president.

### WISCONSIN HOLDS CONFERENCE FOR CRIPPLED CHILDREN AND ADULTS

The State of Wisconsin held its first Conference for Crippled Children and Adults in Milwaukee on February 9.

A state committee was appointed for the purpose of acting as the "steering" body for this conference. A representative body of citizens of the state assembled and interested themselves in forming a permanent organization for the purpose of promoting the interests of the crippled child, with emphasis upon the training and educational program. The problems involved in the rehabilitation of the disabled adult also received consideration.

A survey of twenty industries in and about Milwaukee has been made by the staff of the rehabilitation division of the state board of vocational education. The purpose of this study was to determine to what extent local industries offer opportunities for the employment of the different types of disability. A report of the findings of this study was made at the conference by W. F. Faulkes, state supervisor of industrial rehabilitation.

### THE INTERRELATION OF THE LAITY WITH NURSES

(Continued from page 462)

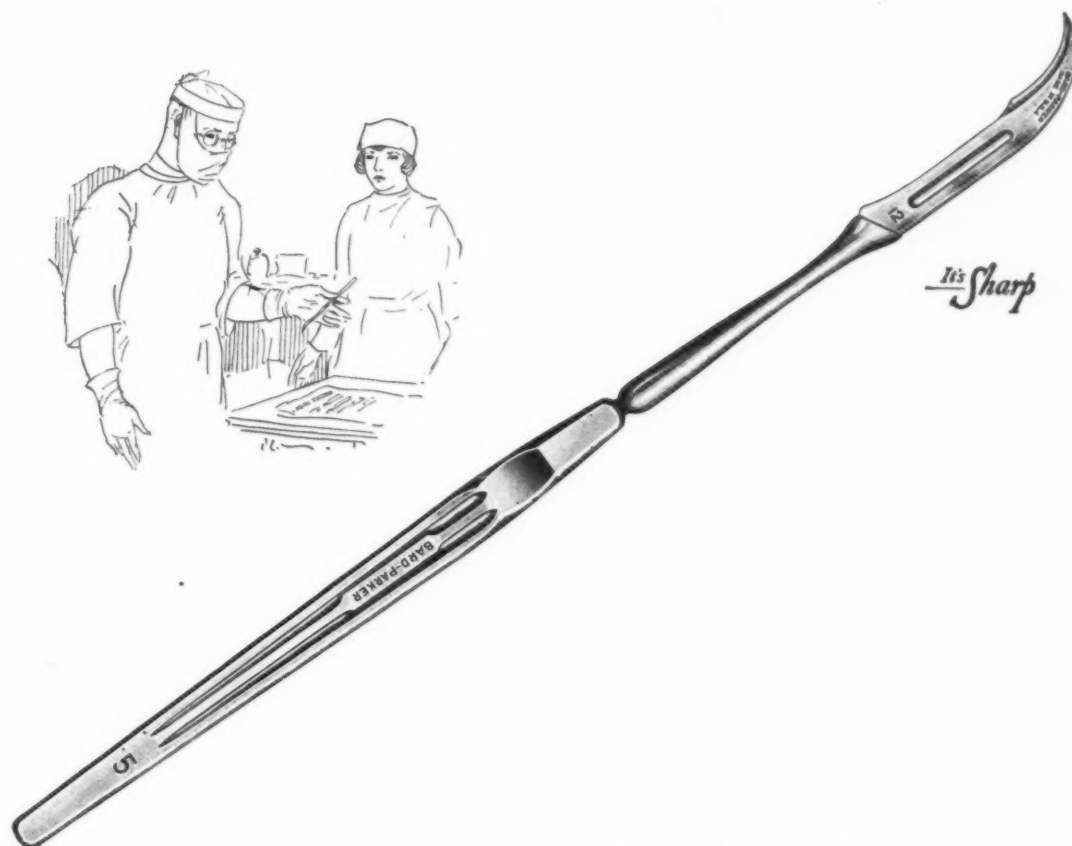
only partially useful results for its expenditure. So, after all, the responsibility comes back in great measure to the laity.

We always have a lay secretary at the head of our Army and Navy. But just in proportion as these secretaries work loyally and thoughtfully with committees made up of professional men will they be faithful to their trust. Lay juries decide whether or not the prisoner at the bar is to be found guilty or innocent, though of course the judge has ample opportunity to express his opinion.

At every point in a democracy the lay public will have the final word. So that perhaps we can say that the greatest crime of the lay public under our system of government is ignorance; in fact, continued ignorance as to the essential interests of the Commonwealth ultimately means the shipwreck of the democratic institution itself.

So now as to nursing, we are at a parting of the ways, when an intelligent, kindly, sensible public must do its part in helping to see justice and fair play done on every side to the sick, to the physician, to the nurse and to society generally. And if we can judge by results in other professions, we will decide that sound education, followed by adequate training, is the best preparation for the intelligent exercise of a practical profession.

The obligations of a hospital to a community are not merely those established by law. There are higher rules for the regulation of hospitals and these involve moral responsibilities to a community, which include an appreciation of some of the finer things in life, the courtesies, the humanities and the spiritualities of human contact. *American Medicine.*



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## HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and  
Housekeeping Problems

Conducted by HERMAN SMITH, M.D., Superintendent  
Michael Reese Hospital, Chicago, Ill.

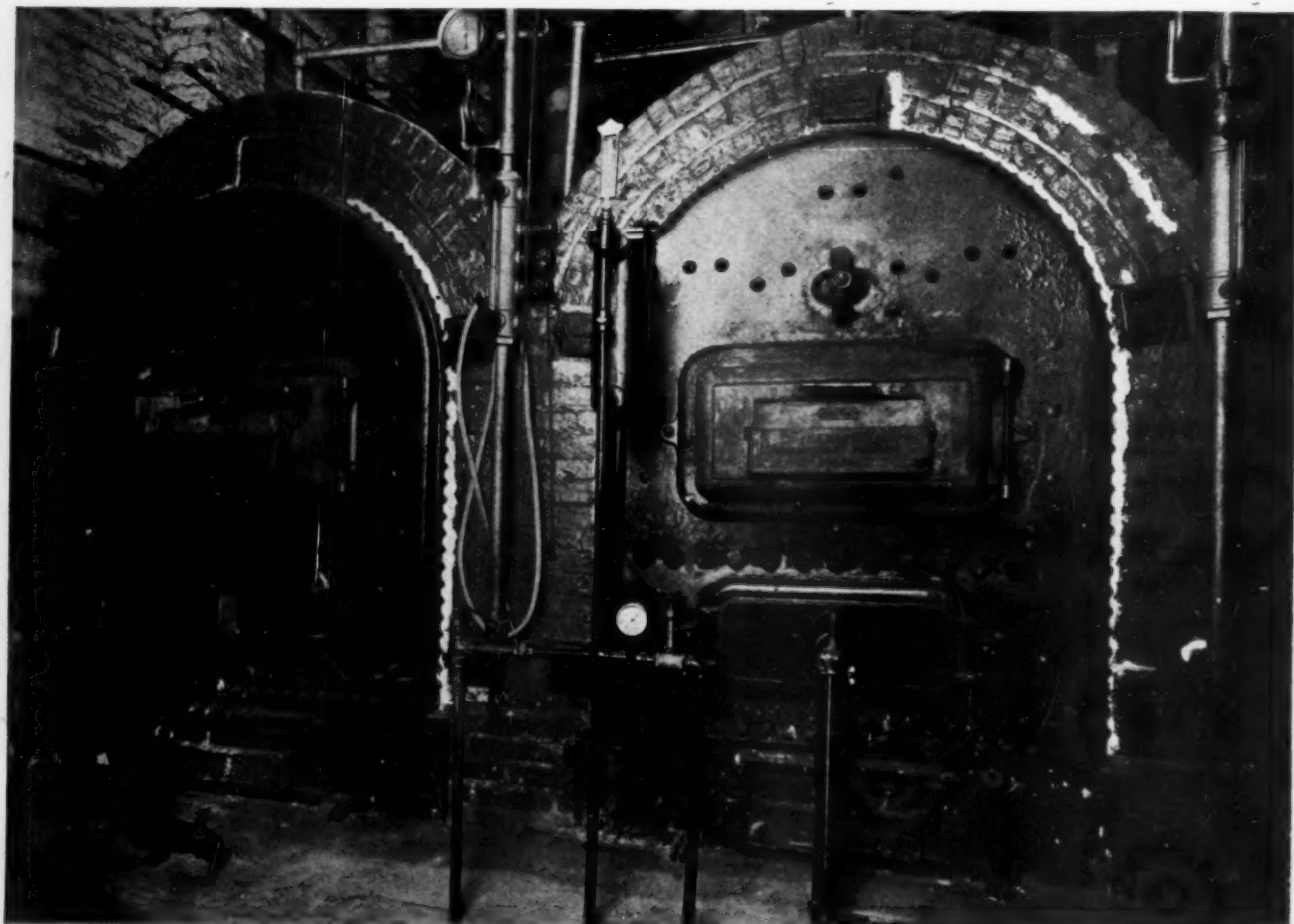
### WHAT YOU SHOULD KNOW ABOUT OIL BURNERS

By Russell Byron Williams,  
Chicago

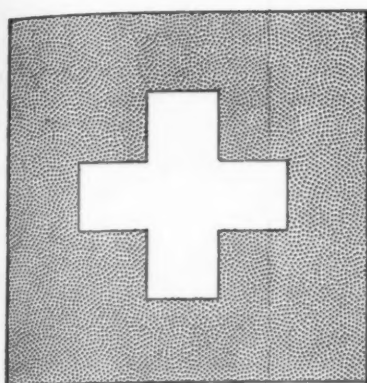
**O**IL burners are now adaptable to almost any type of plant, either high or low pressure. Whether or not they save money depends upon the requirements, location and installation of equipment. The cost also depends upon the size and type of installation. Where coal has been used the fire box should be changed to permit proper oil combustion.

Furnace arrangement for the proper combustion of fuel

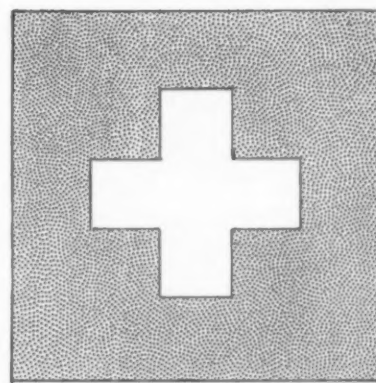
oil is far more simple and embodies none of the complication of arches that are attendant with coal combustion chambers. The contour of an oil fired furnace should be nothing more than a square or rectangular room, with the lower rows of tubes forming the roof. Since atomized or aerated fuel oil should be burned completely while in suspension intense heat is afforded, and the usual arrangement in coal burning chambers will localize this intense



Typical oil burner installation as made under the 100 H.P. boilers of a Pennsylvania hospital.



## Every Hospital can now enjoy the convenience of Gas Service

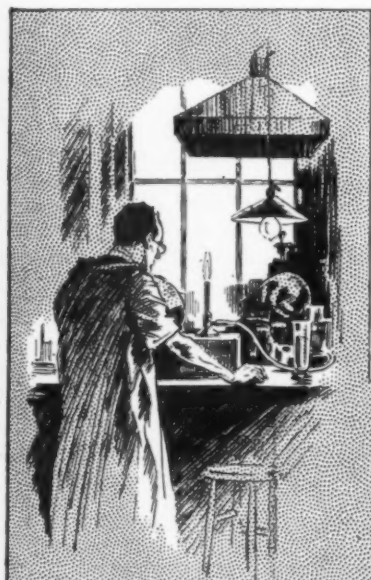


**I**F YOU do not have city gas service, you will find Pyrofax a real convenience in the main kitchen, the diet kitchens and the laboratory.

Pyrofax is made from natural gas and is shipped to the consumer in steel cylinders. It is non-toxic and burns with a clean, hot flame free from soot or odor. It can be used on any standard gas appliance — ranges, hot plates, Bunsen burners, and laundry ironers.

The Pyrofax installation consists of a substantial enameled steel cabinet which houses the cylinders and fittings. It is placed on the outside of the building and the gas is piped from it through ordinary gas pipe to the stoves, burners and other appliances. It is listed as standard by the National Board of Fire Underwriters.

Any further details will be promptly furnished on request. May we not send you our circular and booklet describing Pyrofax?



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Payments of principal can be arranged over a period as long as ten years. Notes to contain a clause permitting the borrower to repay any portion or the entire amount remaining unpaid from time to time.

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heat and cause blistering of fire walls or failure of tubes. Such rapid deterioration of brickwork or frequent replacement of tubes will more than nullify any possible saving effected through the change in fuel and the elimination of ash.

Three important items enter into the design of any furnace for the combustion of fuel oil, namely, volume, atomizer spacing and air supply. Sufficient volume is necessary for the time element in the burning of the vaporized fuel; correct spacing of atomizers eliminates the danger of excessive brickwork deterioration; while correct air supply is imperative to afford proper combustion and yield a high percentage of CO<sub>2</sub>. There is nothing theoretical about this, or is there any oil burner to which these principles do not apply. Hence the need for their universal recognition by every superintendent considering the installation of oil burning equipment.

It is necessary that the superintendent be at least superficially acquainted with the fundamental principles involved in order that he or she may know when the work is properly done.

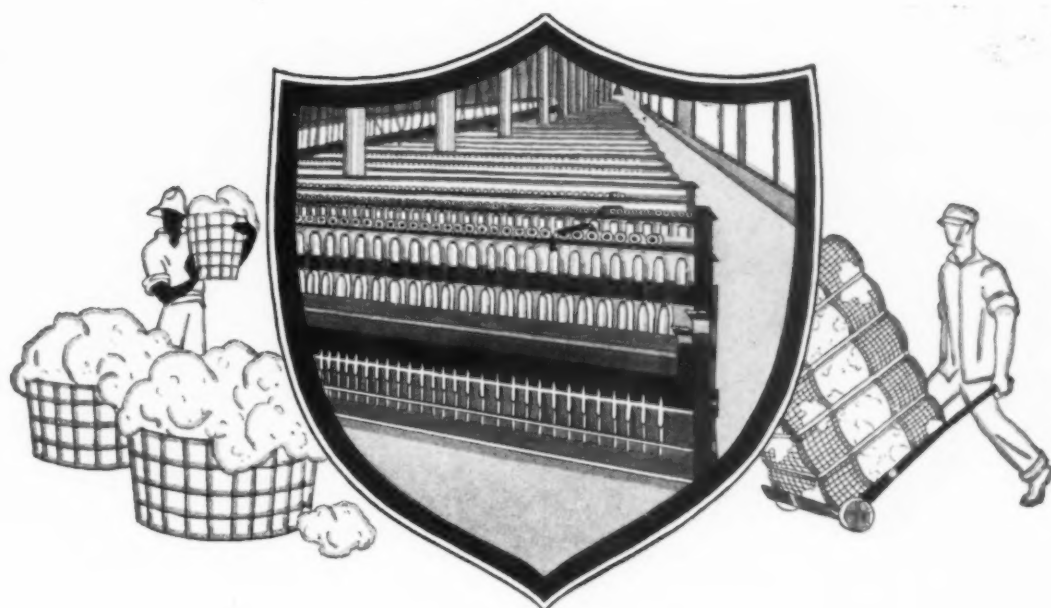
### Amount of Excess Air Important

To detail efficient operation of oil burners it is necessary to group the principle features in several distinct headings. The most important factor in furnace efficiency, regardless of the type of fuel burned, is the supplying of the correct amount of excess air. As explained in this section in one of the previous issues, both an insufficient and an oversupply of air will cause improper combustion and waste fuel. There must be just enough excess of air admitted to the furnace to permit two atoms of oxygen to unite with one atom of carbon. Such a process will develop the chemical compound CO<sub>2</sub>, the percentage of which in the flue gases will indicate the degree of combustion efficiency. Fuel oil combustion is good if the excess air is below 40 per cent and excellent if as low as 15 per cent. With an admission of excess air of from 15 to 40 per cent, a CO<sub>2</sub> content of from 11 to 13 per cent may be obtained, and this percentage of CO<sub>2</sub> while not perfect, is higher than ordinarily found and, therefore, may be considered very good.

Since excess air is by far the most common cause of inefficient furnace operation, it is imperative that every hospital boiler room possess a hand orsat for frequent checking. Without such an instrument, which is not expensive, no engineer or fireman can properly control his fuel bed, if coal; or his flow, if oil; or his air dampers. The intelligent use of a hand orsat is a positive aid in obtaining combustion efficiency and fuel economy. It should be remembered, however, that unless properly handled, even the orsat will be misleading.

The condition of the atomizer is most important when maximum efficiency from fuel oil is sought. To burn satisfactorily, the oil must be thoroughly atomized or broken up, mixed with the proper proportion of air, and burned in suspension under considerable force. Briefly, the process of burning oil is the atomization of the fuel oil, the reduction of the fluid to a gaseous state much finer than ordinary vapor, then forced under pressure to the introduction chamber where it is met by a controlled tornado, a whirling, twisting stream of compressed air traveling at lightning speed. This thoroughly mixes the atomized oil and air, after which it is introduced into the combustion chamber and burned in suspension. In this process it is the atomizer that bears the burden of the hard work. For this reason it demands the greatest amount of maintenance attention.

Four distinct essentials for the proper operation of the



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into every spinning process and it shows in the extra wear that Pequots give under strenuous hospital service.

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atomizers are fineness of atomization, proper straining of fuel oil, proper heating to reduce the internal friction of the fuel and cleanliness of the atomizer tips. Naturally the first of these essentials is wholly dependent upon the other three.

A thorough straining of the fuel oil before it reaches the atomizer is most essential. Silt or fine gritty substances will clog or injure the atomizer tips and render efficient operation impossible. Strainers should be of 26 or 28 mesh, subjected to frequent cleaning, and the area of the strainer no less than three times the area of the fuel line. The reasons for the first two requirements are obvious, while it may be said that the excess area allows for a large amount of accumulation without danger to the pump or without minimizing the oil supply.

Fuel oil is heated before introduction into the furnace principally because such heating reduces its viscosity, or internal friction. There are fuel oils, of course, so low in viscosity that they do not require heating, but in general heating assists oil burner operation by aiding the process of atomization and by reducing pump strain. The temperature for this service should range between 180° and 220° F., the latter figure indicating the maximum.

### Do Not Overheat Oil

According to the U. S. Bureau of Mines there is a great tendency among fuel oil users to overheat the oil. In the bulletin "Efficiency in the Use of Fuel Oil," published by the U. S. Bureau of Mines, it is stated that the capacity of the burner increases as the oil is heated to a certain temperature, that temperature being determined by the viscosity and the expansion relation, but that when heat is applied beyond that given temperature, burner capacity steadily decreases. It should be remembered, however, that it is one thing to heat the oil, and quite another to keep it at the desired temperature until it reaches the combustion chambers. If the pipe lines are long, the desired temperatures can often be maintained by applying a suitable thickness of heat-insulating material. Such details, however, are entirely determined by the individual installation and cannot be discussed here except as items that need attention and thought on the part of the supervising executive.

Indeed, little more than generalities can be given in an article of this kind, not only because the very subject of fuel oil combustion is ramified but because the problems of the hospital are as distinct and individual as their size and character. For the hospital superintendent considering the installation of oil burning equipment, or the substitution of fuel oil for coal, the most logical advice is that which is most easily given and most readily taken, namely, put your heating and steam problem up to a qualified engineer who can familiarize himself with your every requirement and advise accordingly.

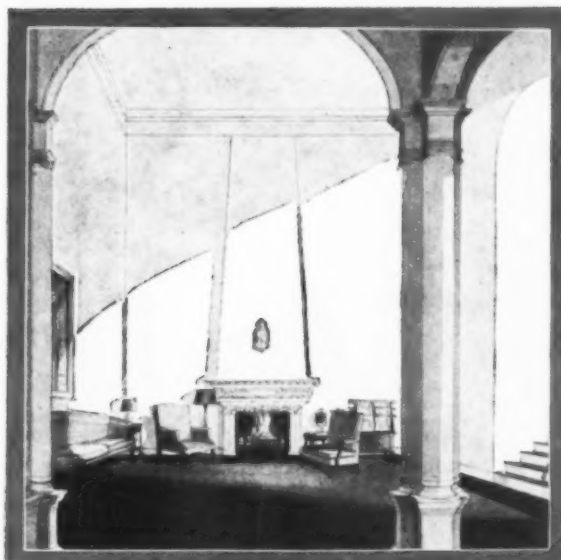
In one hospital where oil burning equipment was installed during the latter part of 1924, the superintendent said:

"Averaging the cost of coal during the last two years, and comparing that cost with the present oil bills, we find a saving of \$44 a month in fuel alone. Added to this is the wages of one fireman at \$110 a month, which brings the monthly saving to \$194, or \$2,330 a year. Apart from the monetary savings, however, we feel that the equipment has proved a decided advantage to the hospital in the elimination of coal handling noise, smoke and soot.

"Our equipment at present consists of two 150-horsepower boilers, high pressures, which were formerly fired with sizes four and five bituminous coals."

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satin-smooth  
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plied under the same conditions—a guarantee made possible by the exclusive Rice Process of manufacture.

Sold in 55- and 30-gallon churn-equipped steel drums, and in cans from ½ pint to 5 gallons. Where more than one coat is required, use Barreled Sunlight Undercoat first.

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## Save Labor Cost and Materials with This New

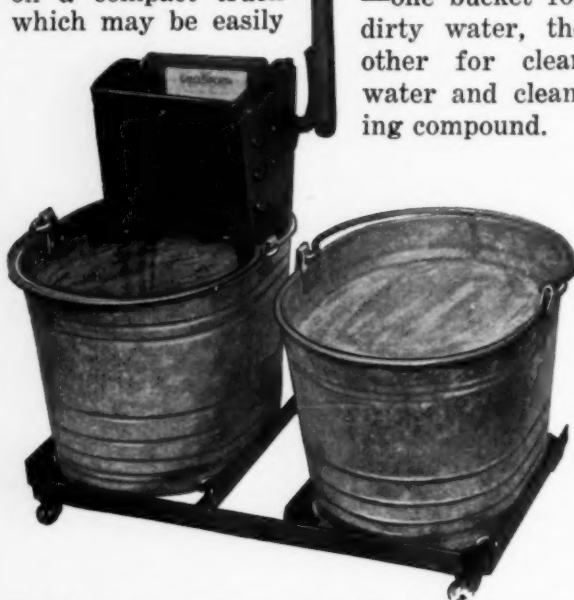
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**CAN'T SPLASH**

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The most sanitary, economical and efficient way of cleaning operating rooms, halls and kitchens.

The outfit is mounted on a compact truck which may be easily

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The buckets rest snugly on an all-steel skeleton truck fitted with ball-bearing casters which glide smoothly over the floor, permitting the outfit to be moved with little exertion. When not in use, one pail with mop wringer fits into the other and the truck may be hung up, the equipment occupying small space.

With the White "Can't Splash" Mop Wringer the mop is not PULLED through rollers and cannot catch or tear. Its simple, all-metal construction eliminates replacement of parts. There is nothing to get out of order. Easy to operate. A pressure on the handle squeezes the mop dry.

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## ETHYLENE VAPORS ARE ELIMINATED

By Louis Cooper Levy, Superintendent, Jewish Hospital, Cincinnati

Danger of explosion and the obnoxious odor—chief deterrents to the use of ethylene gas—have been overcome at the Jewish Hospital of Cincinnati, by the simple expedient of piping the escaping vapor to the outer air.

This has been accomplished through the ingenuity of Dr. Moses Salzer, director of anesthesia, and is presented in this issue so that fellow executives may benefit by our successful experiment.

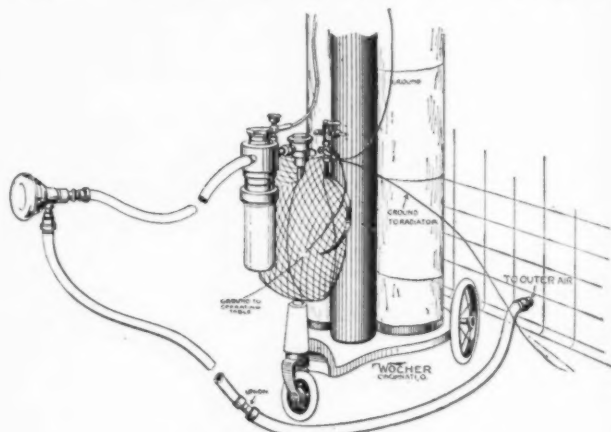
When the Jewish Hospital introduced the use of ethylene, two obstacles militated against its success. First, the escaping vapor caused headaches to the surgeons, assistants and nurses; second, there was a constant fear of explosion as a result of the accumulation of gas in the warm operating room.

To surmount these obstacles, Dr. Salzer inaugurated the following technique:

- No open flame in the surgical pavilion.
- No cauteries or motors of any kind to be used.
- No smoking.
- Elimination of static.
- Elimination of vapor.

It was comparatively easy to bring about adherence to these rules. The responsibility was placed on the supervisor of the surgery and on the anesthetists. As a result no trouble was experienced from the sources named.

If suction apparatus was needed, the old-fashioned water-suction method was used, to avoid the use of an



Showing how ground wires are affixed.

electric motor and the spark that it makes in operating.

The elimination of static was accomplished by affixing grounded wires to the operating table, the gas tank, the water faucet and the radiator.

The elimination of vapor was the real problem. Dr. Salzer noted that in giving an anesthetic with ethylene the warm operating room noticeably retained the gases. How to rid the room of the distasteful odor and at the same time safeguard the lives of those engaged in the operation was accomplished in the following manner:

The Jewish Hospital used a gas and oxygen machine and it was necessary to provide cages to cover the expiratory valves of the mask. These cages are simply pieces of brass tubing, one-quarter of an inch larger in diameter than the expiratory valves, and to these are soldered connections to fit a standard breathing tube. This breathing tube is then connected by a union with standard vacuum-cleaner tubing of one and a quarter inches inside diameter.

The vacuum cleaner tubing is then connected with a

# To meet the specific needs of *Every Hospital* *Curity Absorbent Gauze can now be obtained in two new forms*

THE majority of hospitals have known Curity Absorbent Gauze for over 25 years. They have used it constantly for its excellent quality, unusual absorbency and economy. "So soft and white"—"So remarkably absorbent"—they say.

Now—for the convenience of hospitals where waste cannot be avoided in the preparation of gauze—for hospitals that wish to relieve the nurse from the duty of cutting dressings—Curity Absorbent Gauze may be had in two new forms: Curity Ready-Cut Gauze and Curity Dressing Rolls.

In taking this step forward in the manufacture of gauze for surgical dressings, the Lewis Manufacturing Company has been guided solely by an idea of service. Hospitals are urged to decide whether these new forms of Curity Gauze are more efficient for their individual and particular needs than the regulation 100-yard bolt.

## *The Two New Forms*

Curity Ready-Cut Gauze is the well-known Curity product cut into the most commonly used shapes and sizes for all dressings. These various sizes can be made into gauze dressings, sponges, flats, strips, tapes, walling-off sponges, etc. Folded around cotton or Cellucotton—

they can be made into pads for all types of work.

Curity Dressing Rolls are rolls of Curity Gauze, specially folded (in two sizes) so that the difficult longitudinal folding is done. Just cut the desired length from a Dressing Roll, tuck in the ends, and the completed dressing is ready. Curity Dressing Rolls will serve to make any gauze dressing—abdominal sponges, tapes, wipes, etc. Dressings can be made quickly and with less non-professional drudgery for the nurse.

We shall be glad to send additional information, and samples of Curity Ready-Cut Gauze and Curity Dressing Rolls to hospital executives. Test them and decide which of the three forms of Curity Gauze is best suited to your specific requirements.

LEWIS MANUFACTURING CO.  
{Division of Kendall Mills, Inc.} Walpole Mass.

Lewis Manufacturing Company  
Walpole, Mass.

Please send me, free, samples of Curity Ready-Cut Gauze and Curity Dressing Rolls.

Name \_\_\_\_\_

Position \_\_\_\_\_

Hospital \_\_\_\_\_

Address \_\_\_\_\_

M H 5-26





## Ideal for Kitchens

**T**HERE is no Can quite so handy around the kitchen as the Guaranteed No. 10 Witt Corrugated Can.

Only 18½ inches high by 14½ inches wide it slides under the average work bench or scrap table, yet has ample capacity of 12½ gallons or 1½ bushels—just the right size to save time and muss in handling and dumping.

The construction is 23-gauge special analysis sheet steel, having deep well-rounded corrugations and being reinforced at top and bottom with steel bands.

The handles stop in carrying position, preventing injury to the hands. The lids are interchangeable. The seams cannot spread apart. The entire unit is all hot-dip galvanized *after* being assembled, making it leak-proof and especially attractive.

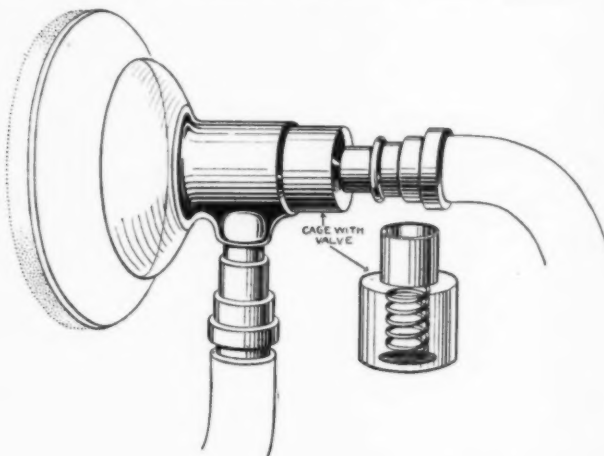
For definite proof of Witt guaranteed economy and service, see your Jobber or write at once to

**The Witt Cornice Company**  
2120 Winchell Avenue  
CINCINNATI, OHIO

Manufacturers of

**WITT**  
**CORRUGATED**  
**• CANS and PAILS •**

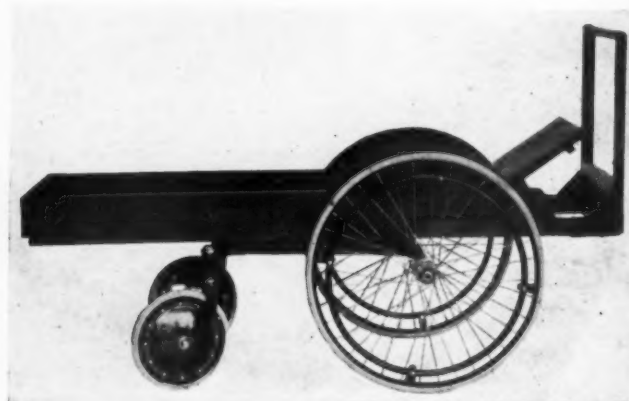
piece of brass tubing leading through the operating room wall to the outer air. When not in use, a cork is placed in this brass tubing to prevent the entrance of cold air into the room, as is shown in the accompanying illustration.



In the opinion of experts the method adopted by Dr. Salzer, and now being used by all the medical anesthetists in the Jewish Hospital, makes the giving of ethylene gas for anesthetic purposes safe, and does away with all the troubles that arise when this form of anesthesia is used.

## IMPROVED CONVALESCENT CART FOR CARRYING CHILDREN

One of the problems presented to a children's hospital or a department caring for children is that of providing means by which the convalescent children and those with orthopedic or other conditions requiring long hospitalization, may be safely transported into new surroundings.



The Children's Hospital, Cincinnati, believes that it has successfully solved the problem after having applied a year's test to a convalescent cart for children. The accompanying illustration shows the cart, which was constructed after careful experimentation concerning specific factors. The resulting conveyance has fulfilled the following necessary qualifications: The cart does not tip at either end; it permits of a comfortable position for the child, whether he is flat upon his back, sitting or reclining, or on a Bradford frame; it is capable of being easily propelled by the small patient who is able to use his arms; the handle bar is at an easy height for a person in an erect position and the side is so arranged as to protect clothing and bedding from being soiled on the wheels.

## Stickley Brothers Hospital Furniture of Character

*Installed in the New Butterworth Hospital  
at Grand Rapids, Michigan, widely known  
as The Furniture Capital of America.*



### Does the Furniture You Purchase Represent the Proper Value for the Price You Pay?

Many times it does not, detailed comparisons and inquiries will invariably demonstrate profound differences of extreme ultimate importance.

The best values cannot be approximated at low prices which in a short time, because of shabby appearance, repairs and replacements, represent a definitely increased cost. A moderate difference in the price you pay for cheap furniture in comparison with a better grade generally represents an extreme difference in value for service, appearance and actual economy.

Careful details in construction and workmanship are of never to be forgotten importance and should not be held in mind superficially by the prospective purchaser of furniture.

Price buying is often time too much of a factor and is not always a good guide for best results. It is better to know the goods themselves and the policy of the firm who makes them.

**Stickley Bros. Company, Grand Rapids, Mich.**

**Manufacturers of Fine Furniture for Forty Years**

*Write for information about our hospital line.*





## Every patient can eat it —as gruel, cereal or in simple delicious desserts

How to cut down on the *number* of different dishes that seem necessary in preparing food for hospital patients—this is one of the dietitian's greatest problems.

Cream of Wheat is one of those all-use foods of inestimable value in a diet kitchen. For every patient can eat it in some form and it lends itself to a wide variety of uses.

For babies and the very sick, as thin gruel; for convalescents, in all sorts of delicious meat and vegetable dishes and dainty desserts; for all, as breakfast cereal.

And it is a very inexpensive food—one serving of Cream of Wheat costs less than 1¢!

Physicians approve Cream of Wheat because of its rich carbohydrate content and its easy, quick digestibility. You can always depend on its uniform quality because it is protected from all contamination in its triple-wrapped-and-sealed box.

Try the recipe below as an economical and easy way to vary your usual menus. Our recipe booklet, "50 Ways of Serving Cream of Wheat," will suggest many helpful new ideas. Sent free.



### LAVENDER FLUFF

½ cup uncooked Cream of Wheat  
1 cup grape juice  
1 cup sugar  
juice of 1 lemon  
whites of 3 eggs  
2 cups water

Let water, grape juice and sugar come to boil, add Cream of Wheat, stirring in slowly, and cook 20 minutes in a double boiler. While still hot add lemon juice and stiffly beaten egg whites. Chill and serve with cream or custard sauce



# Cream of Wheat

Cream of Wheat Company, Minneapolis, Minnesota  
In Canada, made by Cream of Wheat Company, Winnipeg

FOR THIRTY YEARS A STANDARD FOOD ON  
PHYSICIANS' DIETARY LISTS

© 1926, C. of W. Co.

## PRESERVE BY PAINTING

During the spring and summer months many new hospitals will award painting contracts while others will take upon themselves the task of renewing the appearance of their institutions. Such activity plays an important part in the preservation as well as the attractiveness of institutions. And while it is essential that hospital buildings be made attractive and a source of civic pride, it is the element of preservation that makes the periodic application of paint and varnish necessary.

The natural elements of wind, rain, sun, heat and cold, are ceaselessly destructive. Unprotected from these elements any material will rapidly deteriorate. Unpainted wood permits the entrance of moisture, while the sun's rays have a tendency to draw that moisture out. This action alone will cause serious cracking and a general weakening of the material, but would not be so serious if it were not for the fact that the absorbed moisture, before being drawn out by the sun's heat, starts the process of decay. Hence the need for a protective covering, not only to wood but to practically all materials, since the principle of natural deterioration applies in a greater or lesser degree to iron, steel, concrete, clay products or slate.

### Flat-Finish Paint Absorbs Dirt

Then too, there are the artificial elements of destruction such as dirt, dust, smoke and soot, which must be considered when the task of painting or resurfacing is assumed. These artificial elements are more destructive to the general appearance of a structure than to its strength or durability, but they have a direct bearing upon the kind of paint that must be used if the best results are desired.

Only recently the Institute of Paint and Varnish Research completed a long series of tests and experiments, the purpose of which was to determine the relative dirt-absorption qualities of gloss versus flat paints. The fact that these tests have upset some time-honored theories proves their value. It was found, for instance, that flat finishes absorb less dirt and dust than gloss surfaces. This is because in a flat finish there is little pigment exposed, most of the oil having been absorbed by the covered material. While doubtless smoke particles, dust or dirt would find more ready lodging on a flat finished surface, those particles are not absorbed as they are with gloss surfaces, for which reason they are easily dusted or blown off. This fact should have an important bearing on the selection of paint by hospitals, for in localities where soot, smoke, dirt and dust is noticeably heavy, it would obviously be advantageous to employ flat finish paints.

### Influence of Atmospheric Conditions

The proximity of a hospital to a manufacturing district should also be a point for consideration. In many industrial sections the atmosphere is laden with acids and gases that react detrimentally upon the pigments contained in paint and actually effect a chemical change in color, even after the paint has been in service for months. Along the Passaic River in New Jersey, for instance, the acid and gas fumes contained in the atmosphere changed grays to blacks, yellows to pinks, browns to a purplish tint, and whites to varying degrees of gray. Doubtless this action was more noticeable during the dry seasons, a year or two ago, but it remains a fact that such color changes do occur and that hospitals should take into consideration the air content when planning interior decorating schemes. There are various types and kinds

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*PYREX hospital ware not only makes the food look more attractive, more appetizing—but serves to keep it hot while the serving tray is being carried from the diet kitchen to the patient*



*CUSTARDS—and many other healthful delicacies—can be baked in these useful Pyrex individual cups*



*DIETITIANS can appreciate best the greater healthfulness of foods baked more evenly and thoroughly in Pyrex*



*PYREX nursing bottles will not crack or break in sterilizing. They are made in the universally approved 8 oz. size—available in wide mouth or narrow neck styles*

## "PYREX" insures

REG. U. S. PAT. OFF.

*Better service to patients—  
greater efficiency in the kitchen*

**P**YREX Ovenware is particularly adapted to hospital use—both from the standpoint of health, and from that of efficiency.

Tests in the country's greatest cooking school proved beyond any doubt that *foods actually bake better in Pyrex.*

But greater convenience in serving, greater efficiency in the diet kitchen also result when Pyrex is used.

**FIRST: Pyrex permits baking and serving in the same dish—**a significant saving in time and effort when many and varied diets must be prepared. It is made in sizes small enough for individual service—and makes the food look more appetizing and attractive.

**SECOND: Pyrex retains the oven heat—**preventing too sudden cooling, an important point when food must be carried to wards or buildings at some distance from the diet kitchen.

**THIRD: Pyrex is easy to keep sparkling, clean and sanitary.** Its smooth walls, rounded angles, and carefully tested designs permit Pyrex to be placed in the dishwashing machine and cleaned with other dishes.

**FOURTH: Pyrex Ovenware is guaranteed against breakage from oven heat.**

Hospital authorities are asked to write for full information concerning Pyrex equipment to meet their requirements.

*CGW*

CORNING GLASS WORKS  
CORNING, NEW YORK





This nurse is wondering if the heat has penetrated to the center of the package. She delivers doubtful dressings.



This is a SAFE NURSE. She takes no chances. She uses a Diack control every time she sterilizes—she knows.

## YOUR HOSPITAL IS NOT A SAFE HOSPITAL

UNLESS

## DIACK CONTROLS

FOR STERILIZATION

ARE USED TO PROVE

HEAT PENETRATION.

USED IN ALL EFFICIENT HOSPITALS  
Safety Should Accompany Service

100 FOR \$6.00

A. W. DIACK

5533 Woodward Ave.

DETROIT, MICH.



Consumes  
Liquids or Solids

without odor or smoke



Interior View

Interior view of Isolator, showing easy accessibility of receptacle. This is the portable type—can be installed anywhere.

The Isolator reduces ALL hospital waste to ashes in a few minutes. Liquids need not be drained nor it is necessary to pack or prepare waste in any way. Simply deposit in the Isolator and in a few minutes everything is consumed.

We make all types—portable, built-in, etc. Can be installed on any floor—one in each ward is a good plan.

Over 150 hospitals are completely equipped. Isolators have found a place in over 150 institutions; a few are listed below:

Physicians' Hospital ..... Rocky Ford, Colo.  
Soldiers' Home Hospital ..... Sawtelle, Calif.  
Buffalo City Hospital ..... Buffalo, N. Y.  
Grand View Sanitarium ..... Oil City, Pa.  
Lucas County Home ..... Toledo, Ohio  
Hudson River State Hospital ..... Poughkeepsie, N. Y.  
Rockefeller Foundation ..... New York City

Whether or not you are considering installations now, we will be glad to give further facts and prices. Our engineering department is, of course, at your disposal. Write—there is no obligation.

BOCKFINGER & CASS

10 EAST HURON ST.

CHICAGO

Isolators and Amherst Incinerators are manufactured by  
The Buffalo Co-Operative Stove Co.

of "gas-proof" paints available from practically every reliable dealer or manufacturer.

All roofs, regardless of type, need attention at this time of year. The ravages of winter months will now be visible and the need for repair evident. Gravel roofs automatically relieve themselves of "paint" discussion, as do tile roofs. These however, should have inspection to bring into prominence the need for patching, re-tarring, or the replacement of broken tile shingles. Paper roofs should be recoated as a matter of routine, while all shingle surfaces should be painted for the sake of fire hazard reduction if for no other reason. Cedar or other wood shingles become "furred" during the winter months, and this fuzzy surface affords excellent lodging for live cinders, sparks, or burning brands.

Composition roofs, after a period of service, become somewhat worn and porous. At such a time heavy plastic coatings should be applied. This material is of a heavy consistency, and is usually high in asbestos fiber content, so that its application offers resistance to fire and adds to the satisfaction and life of the roof.

### Paint Metal Before Rust Appears

In and about the hospital a great deal of metal is employed, and, generally speaking, every inch of this metallic surface should have a protective coating. Indeed, unprotected metal surfaces contribute materially to excessive overhead, and annually the replacement bill for neglected metal surfaces reaches an enormous sum. This replacement cost, furthermore, could be almost entirely eliminated by the application of paint, since metal is a substance that, when protected with a film of paint, varnish or plating, will last indefinitely. Since there is inherent in all metals the quality of expansion and contraction, such paint coverings should be elastic. It is good, of course, to apply paint to metal just as soon as deterioration or rust sets in, but it is much better to make that application before the rust or corrosion become evident.

While the proper use of paint and varnish has an important place in the maintenance of appearance, its chief function is the prevention of costly replacement, to lengthen life of materials, and to minimize repairs. It is because of the latter and more important function that care should be exercised in the selection of paint or varnish products.

### BRONZING RADIATORS LOWERS EFFICIENCY

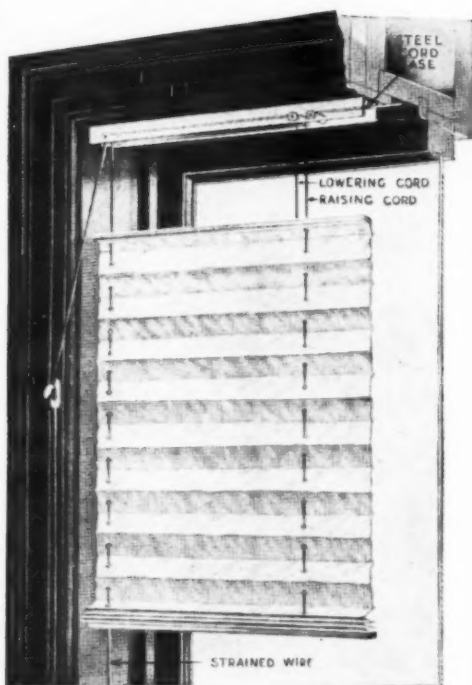
According to the more prominent radiator manufacturers, gold or aluminum bronze paint, so frequently applied to radiators, is a serious detriment to the efficiency of the heating unit. The kind of radiator paint that is used has, it seems, a marked effect on radiation constant. Paradoxical as it may seem, the number of coats has little effect on heat transmission. Only the last, or color coat, possesses inherent paint character that will determine the degree of impediment to radiation constant.

One company, in recommending surface coatings for radiators, used the following table:

Kind of paint	B. t. u. per sq. ft. per hour
White enamel .....	242
Maroon Japan .....	240
Cast iron, bare .....	240
Flat, green enamel .....	230
Gold bronze paint .....	205
Aluminum bronze paint .....	200

# *Athey Perennial* Window Shades

Have been installed in some of the best buildings in your City, because



Detailed drawing showing construction and operation of Athey Perennial Window Shades

Upon request we will be glad to send you a list of buildings in your City, which are equipped with Athey Perennial Window Shades.

*Athey Products*

Perennial Window Shades  
Cloth-Lined Metal Weatherstrips  
Athey Disappearing Partition  
Athey Skylight Shades

## They Conserve Eyesight

Authorities agree that the glare from windows, *improperly shaded*, is one of the chief causes of defective eyesight. The Bureau of Education, of the Department of the Interior, in a bulletin on the subject has the following to say about window shades: "The only satisfactory device is the adjustable fixture whereby any part of the window can be covered."

Athey Perennial Shades can be raised from the bottom or lowered from the top. They can be quickly adjusted to shut out the sun's direct rays without making parts of the room dark.

## Provide Perfect Ventilation Make Awnings Unnecessary

By raising the shades to the top, and lowering to 10 in. from the window stool, and lowering the upper sash about 10 in., the sun's rays superheat the air between the glass and the shades. This superheated air must pass up and out above the sash, drawing old air from the room and automatically providing ventilation.

With Athey Shades no awnings are needed, so that expense and fire hazard is eliminated.

## Nothing to Get Out of Order

They are made of a special Herringbone Weave Coutil Cloth that is *practically indestructible* — and guaranteed sunfast. Rain won't ruin it. They have no springs, latches, catches or rollers to slip, stick or break. They operate on strained wires so they cannot rattle or flutter.

## Last So Many Years They Are the Most Economical

Many of the first Athey Shades made — more than 10 years ago — are still in excellent condition. Installations in hundreds of buildings have proved that, considering their unusually long life, they are the most economical shades obtainable.

*Athey Company*

6052 West 65th Street • Chicago, Illinois

In Canada: CRESSWELL-McINTOSH, REG'D.

270 Seigneurs St., Montreal, Quebec



## A fine prescription that "patients" like to take

KELLOGG'S ALL-BRAN not only relieves constipation—it prevents it. Eaten regularly, it insures natural, healthful elimination.

Physicians and nurses are coming more and more to prescribing ALL-BRAN in the diet. They know they can rely upon Kellogg's because it is 100 per cent bran. Because it provides the "roughage" so necessary to correct faulty elimination—in a quantity no part-bran product can possibly offer.

ALL-BRAN is cooked and krumbled by a special process. Its nut-like flavor is a real treat. Delicious as a breakfast cereal. There are any number of appetizing ways to serve it. Two tablespoons of ALL-BRAN a day is a prescription patients—young or old—like to take!

Sold by all grocers. Served everywhere. Made by Kellogg in Battle Creek, Michigan.



What U. S. P. is to  
drugs, ALL-BRAN  
is to bran foods.

Send to the Kellogg Company,  
Battle Creek, Mich., for recipes  
and health pamphlets.

**Kellogg's**  
the original ALL-BRAN  
—ready-to-eat

## Book Reviews and Current Hospital Literature

### SIMPLIFIED NURSING

By FLORENCE DAKIN, R. N., Instructor, Schools of Nursing, State of New Jersey<sup>1</sup>.

This is an excellent volume for care of the sick in the home, giving simply and clearly procedures on bedmaking, baths, packs, various other treatments, surgical technique, methods of disinfection and sterilization, essentials in good charting as an aid to the doctor, exact amounts of drugs for different percentage solutions commonly used for home disinfection; in short, a most complete book for the use of the lay worker.

It, also, includes important symptoms of the various diseases a knowledge of which would assist in giving more intelligent care to the patient, as well as simple physiology of the various organs and an explanation of the necessity for prescribed treatments.

This book would be very valuable as a text for nurses who desire to conduct classes for women in home care of the sick and for high school girls; particularly, in the latter case since these courses are compulsory in many schools and it is desirable to extend them over the entire year, with their personal hygiene lectures.—M. D.

### PEDIATRIC NURSING

A Textbook for Nurses by ABRAHAM LEVINSON, B.S., M.D., Chicago<sup>2</sup>.

Levinson's "Pediatric Nursing" is a most logically arranged and concisely written book on the care of children.

It should prove to be especially valuable to nurse instructors in the subject, as it follows the new standard curriculum very closely and is free from everything but the essential facts necessary to present to the student.

The chapters dealing with the psychological and sociological problems which commonly confront the nurse in this branch of her work, answer many difficult questions, explain many foibles and superstitions of the laity, and prepare the student nurse to adjust herself to any new environment, whether it be district nursing in the foreign quarter of a great city, or nursing the child in his own home or the wards of her own hospital.—A. A. de S.

### BURDETT'S HOSPITALS AND CHARITIES, 1926<sup>3</sup>

The 1926 edition of Burdett's Hospitals and Charities, the annual handbook of British hospitals and philanthropy, is now available to the hospital world. In this volume, the thirty-sixth edition, the book has been able for the first time to include particulars of the hospitals of the Sudan Medical Service; and the statistics of the military hospitals in India, not available in the last two volumes, have been brought up to date.

<sup>1</sup> J. B. Lippincott Co., Philadelphia.

<sup>2</sup> Lea & Febiger, Philadelphia and New York.

<sup>3</sup> The Scientific Press, Ltd., London.

# 6 more reasons for JEWETT PRESTIGE

\* Stevens Hotel  
Chicago, Ill.  
Holabird & Roche, Architects

\* Hotel Statler  
Boston, Mass.  
Geo. B. Post's Sons, Architects

\* University  
of Chicago Hospital  
Chicago, Ill.  
Coolidge & Hodgdon, Architects

\* Standard Club  
Chicago, Ill.  
Albert Kahn, Architect

\* Bismark Hotel  
Chicago, Ill.  
Rapp & Rapp, Architects

\* Northwestern  
University Hospital  
Evanston, Ill.  
James Gamble Rogers  
and Childs & Smith, Architects

\*Refrigerators by Jewett

## A Partial List of Jewett Equipped Hotels, Hospitals and Clubs

Hotel Pennsylvania  
New York  
Hotel Statler Detroit  
Hotel Statler  
Cleveland  
Hotel Statler  
St. Louis  
Hotel Statler Buffalo  
The Commodore  
New York  
The Biltmore  
Los Angeles  
The Mount Royal  
Montreal  
King Edward Hotel  
Toronto  
The Ritz-Carlton  
New York  
Hotel Fontenelle  
Omaha  
Hotel Syracuse  
Syracuse  
Vanderbilt Hotel  
New York  
The Greenbrier  
Wh. Sulphur Springs  
Davenport Hotel  
Spokane  
Bon Air Vanderbilt  
Augusta  
The St. Regis  
New York  
Hotel Palliser Calgary  
Chateau Frontenac  
Quebec  
Brown Hotel  
Louisville  
The Ten Eyck Albany  
Hotel Vancouver  
Vancouver  
Hotel Cleveland  
Cleveland  
The Texas Fort Worth  
The Onondaga  
Syracuse  
Windsor Hotel  
Montreal  
Chalet Lake Louise  
Laggin  
Hotel Sinton  
Cincinnati  
Simson Hotel Apts.  
Chicago  
The Francis Marion  
Charleston  
The New Palmer  
House Chicago  
New Morrison Hotel  
Chicago  
Michigan Union  
Ann Arbor  
The Royal Montreal  
Golf Club, Montreal  
Rockefeller Institute  
New York  
Post Graduate Hosp.  
New York  
Living-in Hospital  
Chicago  
Santo Tomas Hospital  
Panama

HERE are the six largest refrigerator contracts that have been placed for hotels, hospitals and clubs thus far in 1926—all were placed with Jewett. In each instance (as is usually the case) the Jewett price was the highest among all bids submitted; but Jewett quality was most highly regarded.

Most of these purchasers have been specifying Jewetts for years. The Boston contract, for instance, is for the seventh Statler Hotel to be equipped with Jewetts.

There must be a reason why

such experienced architects and owners consistently prefer these refrigerators. If Jewett engineering and installation service as well as materials and construction were not actually superior, does it seem reasonable that such men would continue year after year to pay a somewhat higher first cost for them?

If you have been considering all refrigerators on a strictly price basis, why not figure on Jewetts for your next refrigerator contract? You, too, will learn why those who now use them find they are the "best buy" obtainable.

THE JEWETT REFRIGERATOR COMPANY  
117 Letchworth Street Established 1849 Buffalo, New York

# JEWETT

REFRIGERATORS



## NEWS OF THE HOSPITALS AND SANATORIUMS

*The department of "News of the Hospitals and Sanatoriums" is prepared each month just prior to going to press, for the purpose of presenting the latest authentic news regarding hospital construction, changes in personnel, and other matters in which the hospital field is interested. So far as we can ascertain, the sources of our information, while not guaranteed, are reliable.*

### General

The following new superintendents have recently been announced: Bertha E. Budworth, San Mateo County Community Hospital, Belmont, Calif.; Dr. Martin H. Collin, Camden County Tuberculosis Hospital, Grenloch, N. J.; Ruth Shepherd, Peekskill Hospital, Peekskill, N. Y.; Dr. Ezra Bridge, Monroe County Tuberculosis Sanitarium, Rochester, N. Y., and Miss E. Russell, White Plains Hospital, White Plains, N. Y.

### California

Dr. F. Leslie Herrick, Oakland, has recently been appointed assistant surgeon at the Napa State Hospital, Imola.

### Florida

According to Dr. John E. Boyd, president of the staff, the Duval County Hospital, Jacksonville, was recently opened. This institution is a general hospital of 230 beds, one-half of which are devoted to the tuberculosis section.

### Idaho

Dr. John W. Givens has resigned as medical superintendent of the state asylum at Orofino, a position which he has held for more than twenty years.

### Illinois

Dr. Charles Davison, professor emeritus of surgery at the University of Illinois and surgeon emeritus at the Cook County Hospital, Chicago, has announced his retirement from the hospital staff. He presided, April 10, at his final clinic, which was attended by all members of the staff. He had been connected with the hospital staff for thirty-four years.

The Michael Reese Hospital, Chicago, was the recipient of a gift of \$600,000 according to the terms of the will of the late Henry L. Frank, philanthropist, which was recently probated.

### Iowa

Mae J. MacArthur, formerly superintendent of nurses, St. Mark's Hospital, New York, has accepted the position

of director of the school of nursing, University of Iowa, Iowa City.

Dr. Campbell P. Howard, formerly professor of medicine at the State University of Iowa, Iowa City, and now a member of the McGill University faculty of medicine, Montreal, and Dr. McKim Marriott, dean and professor of pediatrics at Washington University, St. Louis, Mo., conducted the annual clinic of the College of Medicine at the State University, April 13-14.

Lydia Kral has accepted the position of superintendent and manager of the Denison Hospital, Denison. Miss Kral is a graduate of the Presbyterian Hospital, Chicago.

The fourth annual institute of the Iowa State League of Nursing Education will be held in cooperation with the State University of Iowa at Iowa City, May 4, 5 and 6.

### Louisiana

Dr. Leonard C. Chamberlain has been elected president of the clinical staff of the Presbyterian Hospital, New Orleans, succeeding Dr. Euclid J. Richard.

A gift of \$10,000 to the Touro Infirmary, New Orleans, in memory of the late Emanuel Sternberger, of Greensboro, N. C., is being used to enlarge the department of roentgenology, and to install additional equipment.

A new six-story hospital building is being planned for the St. Joseph Sisters in New Orleans.

The Soniat Memorial Hospital, New Orleans, is receiving bids for the construction of a fifty-bed addition on Annunciation Street; this will be the first of three additions to be made to the hospital, with a total expenditure of \$1,225,000.

### Maine

Bennet S. Ferguson, Brookline, Mass., has established a \$10,000 fund at the East Maine General Hospital, Bangor, in honor of Daniel Goodwin Ferguson and Nancy McIntyre Ferguson. The income of the fund is to be used for the benefit of worthy inhabitants of Dixmont.

### Maryland

Dr. Charles C. Hedges, U. S. public health director for Marshall County, W. Va., has recently accepted the position of second assistant director at the Johns Hopkins Hospital, Baltimore, and will be in charge of the dispensaries. He succeeds Albert W. Buck, who recently resigned to become director of the New Haven Hospital, New Haven, Conn.

**Club Dedicates Twenty-Bed Ward.**—The Lions Club of Baltimore, recently dedicated a twenty-bed ward for crippled children at the Franklin Square Hospital, Baltimore, according to Dr. Newton I. Perry, superintendent of the hospital.

## Hospitals Lose Millions of Dollars

OUT of more than a hundred money-raising campaigns for hospitals each year in the United States there are always many that fail.

The total loss to the hospitals runs into millions.

*The Cause*—these campaigns were placed in the hands of incompetent or inexperienced campaign directors.

*Nothing counts so much in this line of work as successful experience.*

Trustees of Hospitals owe it to the communities they represent to so present their needs as to inspire enthusiasm and goodwill and insure adequate financial response.

*The Only Way* to do this is to place your campaign in the hands of established, experienced, successful directors.

*We are the originators of the Intensive Plan—the modern scientific method of raising funds while promoting community goodwill.*

Following are only a few recent campaigns of hundreds to our credit:

### HOSPITAL CAMPAIGNS

	Objective	Secured
Reading Hospital, Reading, Pa.....	\$1,800,000	\$1,813,000
United Hospital, Rochester, N. Y.....	1,300,000	1,395,000
Arnot-Ogden Hospital, Elmira, N. Y.....	800,000	901,024
Union Protestant Infirmary, Baltimore, Md.....	750,000	810,000
American Hospital of Paris, France (3 campaigns)	500,000	950,000
Washington Hospital, Washington, Pa.....	500,000	523,000
Miami Valley Hospital, Dayton, Ohio.....	500,000	515,000
Methodist Hospital, Fort Worth, Texas.....	500,000	502,512
Presbyterian Hospital, Denver, Colo.....	500,000	500,000
Maryland General Hospital, Baltimore (3 campaigns)	450,000	483,000
Paterson General Hospital, Paterson, N. J.....	400,000	450,000
St. Mary's Hospital, Grand Rapids, Mich.....	350,000	384,316
Memorial Hospital, Pawtucket, R. I.....	300,000	422,190
Sturdy Memorial Hospital, Attleboro, Mass.....	300,000	390,500
Children's Hospital, St. Louis, Mo.....	300,000	330,000
Mercy Hospital, Pittsfield, Mass.....	250,000	328,000
Cape Cod Hospital, Hyannis, Mass. (2 campaigns)		280,000
Toronto Western Hospital, Toronto, Canada.....		210,000
St. Mary's Hospital, Rochester, N. Y.....	225,000	344,890
Norwood Hospital, Norwood, Mass.....	200,000	260,000
Marietta General Hospital, Marietta, Ohio.....	250,000	253,000
Southside Hospital, Bayshore, Long Island, N. Y...	200,000	230,000
White Plains Hospital, White Plains, N. Y.....	200,000	200,000
St. Lawrence Hospital, Lansing, Mich.....	200,000	206,000
Maternity & Children's Hospital, Toledo, Ohio...	150,000	158,500
Methodist Hospital, Sioux City, Iowa.....	125,000	153,500
Pottsville Hospital, Pottsville, Pa.....	100,000	120,000
Hayswood Hospital, Maysville, Ky.....	100,000	116,800
Saratoga Hospital, Saratoga Springs, N. Y.....	100,000	116,000
Evangelical Deaconess Hospital, Freeport, Ill.....	100,000	105,000
Ogdensburg City Hospital and Orphanage, N. Y...	75,000	123,369
United Helpers Home, Ogdensburg, N. Y.....	75,000	116,000
Dobbs Ferry Hospital, Dobbs Ferry, N. Y.....	75,000	116,019
Shenandoah Hospital, Shenandoah, Pa.....	70,000	110,000
Freeman Hospital, Joplin, Mo.....	50,000	51,421
Gilman (Ill.) Community Hospital.....	32,000	32,128

## WARD, WELLS, DRESHMAN AND GATES

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612 Wrigley Bldg., Chicago





MARY FRANCES KERN

## Not Geographical

**T**HE SUCCESS of Mary Frances Kern in the fund raising field is not a matter of geography. Under favorable conditions any campaigner might score in some particular community. The successes of the Mary Frances Kern organization during the past twelve months, however, have ranged from Sherbrooke, Quebec, on the north, to Decatur and Albany, Alabama, on the south, from Pueblo, Colorado, on the west to Passaic, New Jersey and New Bedford, Massachusetts, on the east coast.

Grateful expressions of appreciation over the official signatures of the heads of the institutions served in these cities have appeared in these columns during the past year. In such communities, divergent in geography and character, with different sorts of appeals and under widely varying conditions, there has been one strikingly common feature—the success of the undertaking in raising or surpassing the goal.

The answer is found in the conscientious service which marks Kern-directed campaigns.

## MARY FRANCES KERN FINANCIAL CAMPAIGNS

TORONTO  
73 Adelaide St., West

NEW YORK  
8 West 40th St.

CHICAGO  
1340 Congress Hotel

The Union Memorial Hospital, Baltimore, has arranged plans for a campaign for \$300,000 next October with the assistance of a committee of fifteen, the chairman of which is Dr. John M. T. Finney. The fund will be used to furnish the Johnson Memorial Children's Hospital and Nurses' Home, to pay off a debt on the main building of the hospital, and for general improvements.

### Massachusetts

The Boston Floating Hospital, Boston, Mass., announces its twenty-eighth annual postgraduate course for nurses extending from June 28 to September 15. Only graduate nurses from approved schools of nursing, having had at least two years' training in general nursing, are eligible. Instruction includes lectures by the visiting and auxiliary staff, practical and theoretical work in the food laboratory, supervised ward work and class instruction.

**New Lynn Maternity Building to Open May 1.**—The new \$300,000 maternity building of the Lynn Hospital, Lynn, will be ready for occupancy May 1. The building will be fire-proof, five stories high, and will replace, in the hospital group, three old wooden buildings.

Dr. Hugh Heaton, New York, has been appointed superintendent of the Malden Hospital, Malden, to succeed Rachael McEwan, who recently resigned. Dr. Heaton is a graduate of the Cleveland Homeopathic Medical College.

### Michigan

Dr. George F. Inch has been appointed general medical superintendent of the state hospital at Traverse City, and Dr. Roy A. Morter has been appointed assistant medical superintendent of the state hospital at Kalamazoo, to succeed Dr. Inch. Dr. Morter has been on the staff of the Kalamazoo hospital for a number of years.

Susan Hoag has recently accepted the position of superintendent of the St. Luke's Hospital, Highland Park.

### Missouri

**Opens New Wing.**—St. John's Hospital, St. Louis, has opened a new wing containing a modern pediatric department and attractive children's wards. In the near future a new building for the school of nursing will be erected.

### Montana

Following the rapid completion of the construction work, it is planned to open the new Deaconess Hospital, Billings, by July 1. The hospital will be equipped to care for sixty-seven patients.

### New Jersey

Mrs. Mable Goulette has taken charge of the Paul Kimball Hospital, Lakewood, succeeding Laura McKindles, who recently resigned as superintendent. Mrs. Goulette was formerly assistant superintendent of the hospital. She previously served at St. Luke's Hospital, New York, and during the war was located in the Philippine Islands.

### New York

**Abrahams Reappointed Manager.**—Dr. Robert Abrahams has recently been reappointed manager of the Manhattan State Hospital, Ward's Island, for a seven-year term.

Dr. Christian E. Petersen, Broad Channel, has been appointed full-time superintendent of the Jefferson County Tuberculosis Sanatorium.



## Baltimore hospitals get their bed linens from Utica

Sheets and pillow cases that are economically priced to begin with. Sheets and pillow cases that are soft and smooth—and comfortable. Sheets and pillow cases that bear up under the relentless strain of hospital service.

Utica Sheets and Pillow Cases are all *three!* Is it any wonder that Baltimore casts an almost unanimous vote for Utica?

**No. 1 writes—**

We have used them for years and find they hold up extremely well.

**No. 2 writes—**

These sheets seem tough enough to withstand the hard washings and constant abuse.

**No. 3 writes—**

Hospital linen is subject to hard use and only the best will stand up at all. We have used Utica for many years.

**No. 4 writes—**

We find the Utica mills product most satisfactory for hospital use.

"Greater Economy in Sheets and Pillow Cases" is a booklet written especially for institutions. May we send you a copy?

Prominent Baltimore hospitals thus unite in declaring that Utica Sheets and Pillow Cases are best suited to hospital requirements! And Baltimore is like scores of other cities in this respect. All over the country you find hospitals of the same mind.

UTICA STEAM & MOHAWK VALLEY COTTON MILLS  
UTICA, N. Y.

# UTICA Sheets and Pillow Cases

REG. U.S. PAT. OFF.

For complete index of advertisements refer to the Classified Directory





## Have You Sent for Your Copy?

**"SUCCESS in Raising Money"** is a booklet that discusses concrete facts in their relation to fund raising problems. It is of special interest to hospital boards and superintendents who are now, or may later be, confronted with the problem of raising money for new building construction.

It treats also with the outstanding phases of Ehler Service—how this highly trained organization goes about its work on a given assignment—how it organizes, plans, directs, energizes and stimulates a whole city or community to the point of giving—not only insuring the success of the campaign involved, but leaving behind a general feeling of community pride in accomplishment as well.

A request for a copy of "Success in Raising Money" on your official stationery will be granted immediately, and it won't obligate you in the slightest degree.

**THE HERBERT B. EHLER COMPANY**  
Twelve East Forty-first Street  
NEW YORK

**New Psychopathic Hospital For Westchester County.**—The board of supervisors of Westchester County approved the building of a new psychopathic hospital following a survey of the facilities of the county for the temporary treatment of mental disorders conducted last year by the National Committee for Mental Hygiene and the state mental hygiene committee.

Bessie Budd, St. Stephen, New Brunswick, was recently appointed superintendent of the Yonkers Homeopathic and Maternity Hospital, Yonkers.

John G. Copeland, M.D., has recently been appointed superintendent of the Albany Hospital, Albany.

The Flushing Hospital corporation, Flushing, recently voted to begin a campaign, May 1, to raise \$750,000 to enlarge the institution. A plot of ground has already been secured at Elm Street and Parsons Boulevard.

Montefiore Hospital, Bedford Hills, will soon build a new sanatorium for tuberculosis patients on the site of its present institution in Westchester County. The new structure will accommodate 230 patients.

According to a recent report by the Hospital Information Bureau of the United Hospital Fund of New York, there are women superintendents in sixty of the 134 public and private hospitals in New York. Twenty-six per cent of the institutions included in the report have women, exclusively, on their boards, and 50 per cent have men only on their boards. Fifty-six per cent of the patients in the general hospitals were women.

Dr. George D. Stewart has been appointed medical director of the Broad Street Hospital, New York.

Austin J. Shoneke was recently appointed superintendent of the Lutheran Hospital of Manhattan, New York. Mr. Shoneke for the past six years studied hospital administration at Mount Sinai Hospital, New York, under the direction of Dr. S. S. Goldwater.

According to Aldermanic President McKee, member of the special committee of the Board of Estimate of New York to study the conditions and needs of the city hospitals, there is a need of \$30,000,000 to place the municipal institutions of New York in good condition. The quarters are cramped, equipment is lacking and the nurses are for the most part underpaid in the opinion of Judge McKee.

On the basis that a community should provide convalescent hospitals for from 12 to 15 per cent of its total bed capacity, New York, with 400,000 hospital patients annually, requires provision for 56,250 convalescents, according to a survey recently made by the Hospital Information Bureau of the United Hospital Fund. Yet, in a total of sixty-one institutions of this kind only 30,000 patients may be accommodated. This situation will be somewhat relieved when additional institutions planned by several associations are finished but even then the total capacity will not be sufficient to meet the needs of the convalescents.

### North Carolina

The Pitman Hospital, Fayetteville, recently awarded contracts and construction work has begun on a \$100,000 addition to the present hospital building.

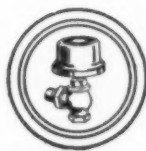
According to Dr. Furman Angel, superintendent, the \$25,000 addition to the Angels' Brothers Hospital, Franklin, will be opened to the public on May 1.

The new \$150,000 Davis Hospital, Statesville, with a capacity of fifty beds, was recently completed and thrown open to the public.

Dr. Joseph Rush Shull has been appointed roentgenologist to the St. Peter's Hospital, Charlotte.

### Ohio

County to Defray Tuberculosis Expenses for Year.—The



## Hospital Attention

**M**ANY hospitals are equipped with The Johnson System of Temperature and Humidity Control. Their names and what they interestingly say will be gladly furnished on request. Every hospital ought to be equipped with The Johnson System of Temperature and Humidity Control: for the same big reasons these many other hospitals find it so successfully valuable. The great fuel saving of 15 to 35 per cent annually; the advantages and convenience of automatic regulation of each hospital room's temperature, extremely accurate as prescribed; the prevention of overheating and costly property damage resulting; and the utter reliability of Johnson performance: cause wide-spread praise among hospitals Johnson equipped. And, indeed, is sufficient to arouse all hospitals' attention.

*Johnson All Metal Design and Construction, Including Thermostats and Valves, Prevent Every Possible Failure of Operation: And Is the Final Advancement to Perfect Automatic Heat Regulation.*

## JOHNSON SERVICE COMPANY

Milwaukee, Wisconsin

AUTOMATIC TEMPERATURE REGULATION SINCE 1885

TWENTY-NINE BRANCHES

UNITED STATES AND CANADA

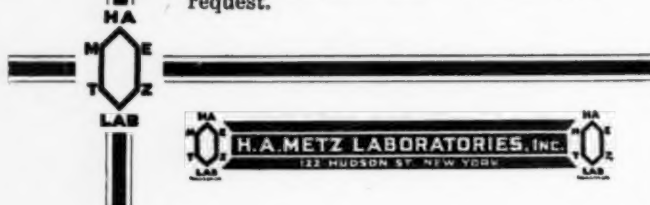


## For use in the Operating Room

—where the preparation of large quantities of anesthetic fluid is desirable, **CONCENTRATED NOVOCAIN SOLUTIONS (20%)**, with and without **SUPRARENIN**, in ampules of 1.5 cc. and 5 cc. are recommended. The concentrated solution may be readily diluted before injection with sterile, physiologic salt solution to the strength desired, usually 0.5%.

For synergistic analgesia, we market **MAGNESIUM SULPHATE** Solutions with **MORPHIN** and **NOVOCAIN**, made by us in accordance with Doctor Gwathmey's formulas.

A complete list of **NOVOCAIN** products—crystals, tablets and solutions in ampules with and without **SUPRARENIN**—will be sent upon request.



## The New York Post Graduate Medical School and Hospital

OFFERS A  
**SUMMER COURSE**

IN  
**Hospital Administration**

Four Weeks, Beginning July seventh  
**Limited Registration**

*For Particulars Write:*

Col. Peter Murray, Assistant Superintendent  
303 East 20th Street,  
New York City.

Hamilton County Commissioners have agreed, by resolution, to defray the expenses of operating the tuberculosis branch of the General Hospital, Cincinnati, for the coming year, because of the financial condition of the city. The estimated cost for the tuberculosis branch is given at a quarter of a million dollars.

The Charity Hospital, Cleveland, Ohio, nurses' alumnae association has elected the following officers for the year: President, Elizabeth Quinn; first vice president, Mary Fisher; second vice president, Rose Daughn White; recording secretary, Mary Dwyer; corresponding secretary, Florence T. Brady, and treasurer, Jeanette Focke.

**Appointed Head of New Tuberculosis Sanatorium.**—Dr. William M. Garrison, Bangor, Me., has been appointed head of the Belmont County Tuberculosis Sanatorium, which is to be completed and placed in operation this spring.

**Hoover Named At Alliance Hospital.**—Frank W. Hoover has been appointed superintendent at the Alliance City Hospital, Alliance.

Dr. Frank C. English, executive secretary of the American Protestant Hospital Association, who has been connected with St. Luke's Hospital, Cleveland, for the past ten years, will sever his connection with that hospital on June 1 in order to take up new duties as executive manager of Christ's Hospital, Cincinnati, Ohio.

Mr. and Mrs. Frank H. Mason, Akron, have donated \$50,000 to the new Children's Hospital, Akron, as a memorial to their daughter. The drive to raise more than a half-million dollars for the hospital is nearly completed. The People's Hospital, Akron, appropriated \$1,000 as a contribution to the campaign.

Dr. F. M. Houghtaling, health commissioner, was in charge of a chest clinic recently held at the Good Samaritan Hospital, Sandusky.

Mrs. Sarah A. Heatley, Toledo, was appointed superintendent of the Memorial Hospital, Fremont, for the remainder of the year at a recent meeting of the board of trustees.

### Oklahoma

Edith Gatin recently assumed the superintendency of the Hollis Hospital, Hollis. Miss Gatin was formerly connected with the Altus Hospital, Altus.

St. John's Hospital, Tulsa, was recently opened to the public with a present capacity of eighty beds. It is expected that the remainder of the \$1,500,000 hospital building will be completed by fall which will bring the bed capacity to 300.

Dr. David D. Paulus, Oklahoma City, has been appointed superintendent of the Oklahoma City Clinic and Wesley Hospital, Oklahoma City, to succeed George D. Hansen, resigned.

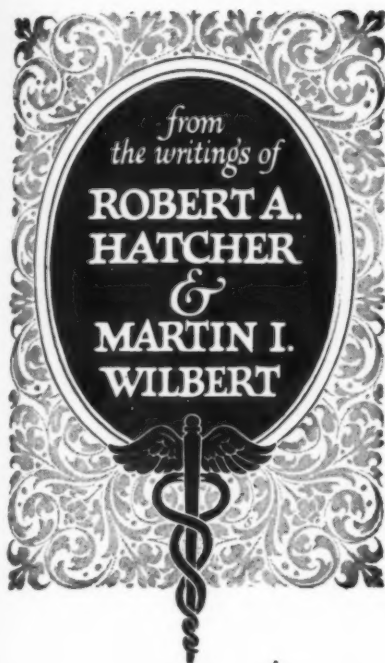
### Pennsylvania

Margaret J. Robinson, superintendent of the Montefiore Hospital of Western Pennsylvania, Pittsburgh, has been granted a leave of absence from her duties at the hospital and will leave June 10 for a short vacation in Europe. Her itinerary includes Paris, Brussels and London where she will visit numerous hospitals before her return to the United States, July 18.

Dr. George A. Ulrich has been appointed chief visiting obstetrician to the Northwestern General Hospital, Philadelphia.

**Dedicate St. Luke's Hospital Wing.**—The new wing of the St. Luke's Hospital, Bellingham, which was erected at a cost of \$100,000, was recently dedicated.





**"VERY** few cases of poisoning by caffein have been recorded, and in view of the enormous use of the beverages containing caffein we must suppose that it is not a dangerous drug so far as the immediate peril of life is concerned; but minor toxic symptoms, including nervousness, cardiac irregularities, sleeplessness, lassitude, ill humor and headache, are common; these usually call for no other treatment than the discontinuance of the beverage which is causing the trouble."

## Postum will help you banish the "minor toxic symptoms . . ."

When you find you must order the "discontinuance of the beverage which is causing the trouble," tell your patient to try Postum. Once his craving for stimulation is a little dulled, your patient probably will join the 2,000,000 American families who drink Postum regularly, and there will be no recurrence of the "minor toxic symptoms."

Four out of every five persons who make Postum properly and try it for 30 days will hold to Postum as their preferred mealtime drink. This fact has been established by a recent study among a large group of people.

In Postum there is no trace of drug stimulants. Its ingredients are whole wheat and bran, skillfully roasted, with a little sweetening—and nothing else. Instant Postum made with hot (not boiled) milk is a satisfying, nourishing drink for everyone, particularly for children and convalescents.

POSTUM CEREAL COMPANY, Inc., Dept. M. H. 5-P. Battle Creek, Mich.



*We will be glad to send the physician who addresses us a special gift package containing a full-size package of Instant Postum, together with samples of other Post Health Products, which include Grape-Nuts, Post Toasties (Double-thick Corn Flakes), and Post's Bran Flakes.*

If you live in Canada, address CANADIAN POSTUM CEREAL Co., Ltd.  
Dept. M. H. 5-P, 45 Front Street East, Toronto 2, Ont.



## Oakite assures the CLEANLINESS hospitals demand

**H**OSPITALS appreciate the true value of scrupulous cleanliness. They know that dirt in any form, anywhere, is a constant menace to hygienic sanitation and good health.

Any cleaning material that is used, however, not only must clean thoroughly, but also quickly and economically. It should not injure equipment.

Oakite meets all these exacting conditions. It contains no lye, caustic, soda ash, ammonia, grit, oxalic acid or soap. It cleans thoroughly, without injurious action on skin or clothing, and without leaving a film to collect bacteria or dust. It is notable for its free rinsing qualities. Nothing better has been found for washing floors than Oakite. This remarkable detergent has a wide and varied use in hospitals. Note the list below.

Floors and walls  
Painted and varnished surfaces  
Windows and mirrors  
Carpets and upholstery  
Washstands, bath tubs, toilets and  
sick room appliances  
Laundry work  
Dishwashing  
Glassware

Cutlery and silverware  
Aluminum ware  
Cooking utensils  
Dairy bottles  
Dairy cans  
Dairy utensils  
Engine room equipment  
Garage  
Surgical apparatus

Our booklet "Oakite in Institutions" gives complete information. Write for it.

*Oakite Service Men, cleaning specialists, are located at*

Albany, Allentown, Pa., \*Atlanta, Ga., Baltimore, \*Boston, Bridgeport, \*Brooklyn, Buffalo, Camden, Charlotte, N. C., \*Chicago, \*Cincinnati, \*Cleveland, \*Columbus, O., \*Dallas, \*Davenport, \*Dayton, \*Denver, \*Des Moines, \*Detroit, Erie, Flint, Mich., \*Grand Rapids, Harrisburg, Hartford, \*Indianapolis, \*Kansas City, \*Los Angeles, Louisville, Ky., \*Milwaukee, \*Minneapolis, \*Montreal, Newark, New Haven, \*New York, \*Oakland, Cal., Peoria, Philadelphia, \*Pittsburgh, Portland, Me., \*Portland, Ore., Providence, Reading, \*Rochester, Rockford, Rock Island, \*San Francisco, \*Seattle, \*St. Louis, Syracuse, \*Toledo, \*Toronto, Utica, \*Vancouver, B. C., Williamsport, Pa., Worcester.  
\*Stocks of Oakite materials are carried in these cities

# OAKITE

**Industrial Cleaning Materials and Methods**  
OAKITE IS MANUFACTURED BY OAKLEY CHEMICAL CO.  
18A THAMES ST., NEW YORK, N.Y.

### Rhode Island

The new \$150,000 South County Hospital, Wakefield, was recently dedicated. Facilities have been provided for twenty-two beds at present, although the completed building will accommodate almost twice that number of patients.

### South Dakota

A plan is under way at Camp Crook to form a hospital association, to be known as the Harding and Carter County Hospital Association.

### Texas

**Offer \$10,000 for Tubercular Children's Hospital.**—With the idea of creating sufficient facilities for the care of tubercular children of Dallas, a citizen recently offered a gift of \$10,000 for the erection of a hospital building at Parkland Hospital, Dallas, providing the board of trustees raises an additional \$35,000.

Miss N. Chappelle tendered her resignation as superintendent of the City-County Hospital, Ranger, to become effective April 15. No successor has as yet been appointed.

Mother George, for fifteen years superintendent of the Spohn Sanitarium, Corpus Christi, and lately mother superior of St. Joseph's Infirmary, Fort Worth, died following an attack of influenza.

Dr. A. D. Patillo was recently elected president of the board of Wichita General Hospital, Wichita Falls, to succeed Dr. Everett Jones, who resigned to take charge of the new Wichita Falls Medical and Surgical Clinic Hospital.

### Washington

**Tuberculosis Sanatorium Opens Near Seattle.**—The Firlands Sanatorium, a city institution near Seattle, has opened a new \$60,000 building with a capacity of sixty beds, for the treatment of tuberculous children.

### West Virginia

Dr. M. V. Godbey, Charleston, was recently appointed by Governor Gore to succeed Dr. H. L. Goodman as superintendent of the McKendree Hospital, McKendree. The Governor also reappointed Dr. J. G. Pettit head of the state tuberculosis sanitarium at Hopemont.

### Wisconsin

Dr. Frank P. Gaunt, formerly connected with the Mayo Clinic, Rochester, Minn., has accepted the position of medical director of the Emergency Hospital, Milwaukee, according to Health Commissioner J. P. Koehler. Dr. Gaunt was chief surgeon and general superintendent of the Wuhu General Hospital, Wuhu, China.

### Canada

Dr. Peter McNaughton, medical superintendent of the Ontario Hospital for the Insane, Brockville, Ont., died March 8. Dr. McNaughton had been associated with the Ontario institutions for the insane for many years. He was vice-president of the Ontario Neuro-Psychiatric Association.

Construction work has been started on a 100-bed addition to St. Joseph's Hospital, Winnipeg, which will double the capacity of the present building. The new building will be three stories high, and will contain three operating rooms and a maternity department.

Irene Smith has entered upon her duties at the General Hospital, Regina, Sask., following her appointment as superintendent of nurses.

# Clinical Procedures Photographically Recorded

Every clinician subscribes to the value of photographic records—and they're easily made.

The Eastman Clinical Camera, designed to meet every clinician's needs, is as simple to use as a Kodak. It has the finest of lenses, a Kodak Anastigmat *f.7.7*, takes 5 x 7 pictures on film or plates and can be used in all positions from vertical to the horizontal. A scale indicates the exact reduction of the picture from life size.

A new book, "Clinical Photography" just off the press, is convincing proof of the value of photographic records in clinics and hospitals. A copy will be sent you, on request.

Eastman Kodak Company

*Medical Division*

Rochester, N. Y.





## SANISORB

*"The ideal absorbent"*

The fluffy snow-white rolls of Sanisorb will prove a delight to those who make up your surgical dressings and pads. Sanisorb is a wood pulp cellulose product far superior to absorbent cotton. It is much more absorbent, is low in price, and economical and convenient to handle and use. For hospital use Sanisorb is put up in rolls averaging fifteen to seventeen pounds each. Deliveries are immediate.

**27c** Per Pound  
In 100 pound lots  
**FREIGHT PAID**

*Discounts on large quantities*

The above price is for Zone 2 including all states east of the Mississippi River and Minnesota, Iowa, and Missouri. In Zone 3 including all remaining states west of the Mississippi River and east of the Rocky Mts. add 1c per pound. In Zone 4 including all states in the Rocky Mts. and west thereof, add 3c per pound.

**WILL ROSS, Inc.**

457-459 E. Water St.  
MILWAUKEE, WIS.

Note the convenient way in which Sanisorb is packed, each roll in a strong fibre container protecting the contents against soiling and damage and increasing the convenience in storing and handling.



Dr. A. W. Hunter has resigned his position as pathologist to the Vancouver General Hospital, Vancouver, in order to devote more time to his private practice. He will remain a member of the visiting staff of the hospital.

**Victoria Hospital Destroyed by Fire.**—The Victoria Hospital, Renfrew, Ontario, was recently destroyed by fire, causing a loss estimated at \$75,000. The fire, which ruined the building and its contents, was caused by a defective flue or electric wiring in the roof of the main building.

### Foreign

**To Reorganize Peru Hospital Service.**—By reason of a recent decree, the Ministry of Promotion of Peru, which includes the Public Health Bureau, has been designated to study a plan for reorganizing the hospital service of the Republic, prepared by a committee appointed for this purpose. The committee was composed of the director of public health, chairman; one delegate designated by the school of medicine; two hospital physicians appointed, respectively, by the public charities of Lima and Callao; and two physicians appointed by the minister of promotion and the professor of hygiene of the school of medicine, respectively, the latter acting as secretary.

**New Medical School in India.**—The King Edward VII Memorial Hospital and the Seth Gordhandas Sunderdas Medical College at Bombay were opened by the governor January 22. The medical school will accommodate 300 students and the hospital 304 patients, with provision for expansion to 400 without overcrowding. The institutions, which cost nearly \$3,000,000, were made possible by contributions from the government, the municipality of Bombay and individual benefactors.

**Plan Hospital Improvement at Bahia.**—According to Consul Howard Donovan, Bahia, Brazil, a recent decree authorized the expenditure of approximately \$71,000 for increasing the number of beds and for the addition of an unspecified number of rooms at the Hospital da Santa de Misericordia, Bahia.

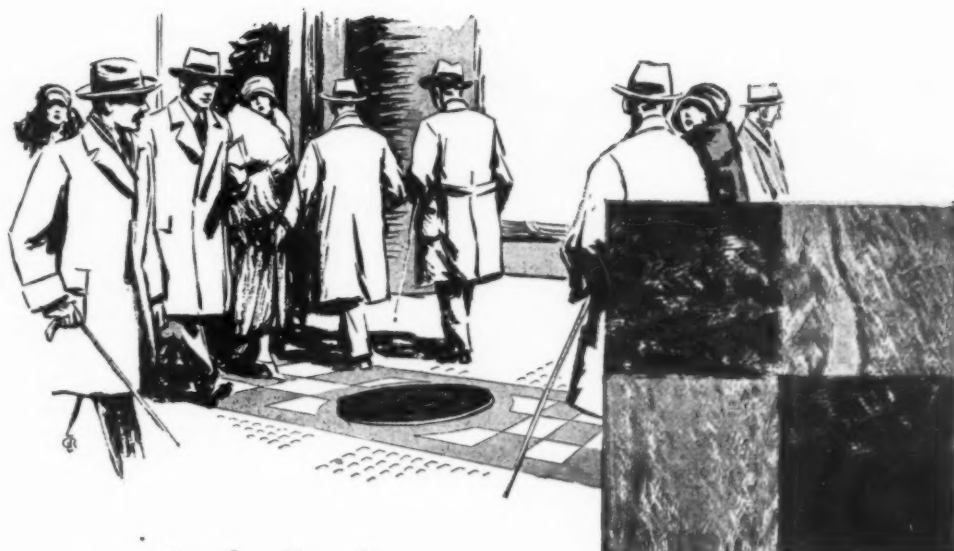
### PORTLAND PLANS JUVENILE HOSPITAL FOR DELINQUENT GIRLS

A new juvenile hospital is being built in Portland, Ore., by the Pacific Protective Society for the care of the delinquent girls at the Louise Home for Girls. The hospital, which will accommodate thirty beds and will be fully equipped with operating rooms, treatment rooms and offices, will be built on a twenty-one acre tract of land, about nine miles from Portland at Elwood Station. The work of the protective society is supported by the community chests, state aid and private contributions.

The building will be three stories high, the third story of which will contain a large convalescent ward. It is planned to have an obstetrical wing and special quarters for the segregation of venereal disease patients and also contracted cases of juveniles up to the age of twenty-one. The project is partly supported by the state, the legislature having appropriated \$17,500.

### NURSING SCHOOL AFFILIATIONS

The Yale School of Nursing, New Haven, Conn., has entered into affiliations with twenty-one hospitals in New York and New England by which nursing students in these institutions may avail themselves of its advantages. The instruction available through its various departments gives a basic preparation for teaching and administrative positions. The majority of the students who enter the course at the Yale School of Nursing are college graduates.



## 16 Years service as a public thoroughfare

SIXTEEN years ago, on the sidewalk before the B. F. Goodrich Company Building, at 1780 Broadway, New York City, we inserted an inlay of Goodrich Rubber.

Today, in spite of the tread of millions of feet and the exposure to every weather extreme, it shows only the slightest sign of wear. One fact is assured—Goodrich knows how to put durability into such products.

That is the prime reason for the wide choice of Goodrich Rubber Flooring by

Builders and Architects—it is practically a permanent floor covering.

But it has other pronounced advantages. It is sanitary and noise-deadening. It is non-porous, and its smooth surface can be kept clean and aseptic. Strong soaps or alkalies will not damage.

Another Goodrich advantage—this flooring comes in rolls. It is vulcanized into a solid sheet with no seams. It is more sanitary with less chance to collect dirt, and it costs less to lay in the beginning. *Send for catalog and samples.*

THE B. F. GOODRICH RUBBER COMPANY *Established 1870 Akron, Ohio*

# Goodrich Rubber Flooring

SUPPLIED IN ROLL FORM

## THORNER'S Silver Service



Thorner's Silver Service is made of 18% Nickel Silver with a quadruple silver plate. Wears a lifetime. Replacement through breakage is forever eliminated. It is never affected by wear or polishing.

Illustration features Thorner's Improved Three Compartment Hot Water Plate. Tea Set with reinforced bands, hard metal hinges, Silver Soldered and one-piece unbreakable bottom. Covered Soup Cup with Silver Soldered handles. Sherbet Dish, Individual Bud Vase, Salt and Pepper Shakers, and Superior Grade Sectional Plate Flatware. Illustrations and estimates submitted upon request.

THORNER BROS.—Exhibit Booth 22  
Catholic Hospital Association  
June 14th to 17th inclusive  
Loyola University Gymnasium  
Chicago, Ill.

## THORNER BROTHERS

Importers and Manufacturers of  
Hospital and Surgical Supplies  
386-390 Second Avenue  
NEW YORK CITY

### Trade News and Publications

**Graybar Electric Names Vice-Presidents.**—The Graybar Electric Company, New York, successor to the supply department of the Western Electric Company, recently announced that Leo M. Dunn, formerly general merchandise manager, has been appointed vice-president, in charge of merchandising and accounting, and George E. Cullinan, formerly general sales manager, has been named vice-president, in charge of sales, and a director of the company.

**Palmer Named Sales Director.**—J. W. Palmer, formerly assistant manager of the china department, Albert Pick and Company, Chicago, has been appointed special sales director of that company.

**Hospital Silverware.**—The Gorham Company, silversmiths and goldsmiths, New York, has recently distributed "Hospital Silverware," a catalog which portrays many of the Gorham products that are manufactured especially for use in the modern hospital. The catalog includes users of Gorham ware, specifications of flatware and hollow ware and illustrations of the many adaptations to hospital usage.

**Faichney Instrument Corporation.**—The Faichney Instrument Corporation, Watertown, N. Y., have distributed their 1926 catalog, "Clinical Thermometers and Surgical Supplies," which has been divided into sections to present better the supplies manufactured by the corporation.

**Occupational Therapy.**—Eaton Rapids Woolen Mills, Eaton Rapids, Mich., have issued a folder dealing with the adaptability of woolen products to the occupational therapy department of a hospital.

**First Aid Supplies.**—Diamond Manufacturing Company, New York, dealers in first aid supplies, have issued a folder calling attention to bargains in supplies.

**The Paper With a Smile.**—The Paper Mills' Company, Chicago, paper merchants and envelope manufacturers, has recently distributed a folder illustrating the advantages of using Gold—"The Paper With a Smile," which is one of their newer products.

**Harold Surgical Corporation.**—The Harold Surgical Corporation, New York, recently issued Catalog 1, Volume III, which lists equipment for the physician and surgeon.

**"The End of the Search."**—An attractively prepared pamphlet, "The End of the Search," dealing with Hart Oil Burners for homes and other buildings, has been received from the W. B. Wilde Co., Peoria, Ill.

**Where People Go, and Why.**—The Ligonier Refrigerator Co., Ligonier, Ind., has recently distributed a broadside, "Where People Go, and Why," which treats of the advantages of refrigerators and refrigerator display counters that attract the attention of customers to food products for sale.

**Flexible Fixture Hangers.**—Crouse-Hinds Company, Syracuse, N. Y., have prepared Bulletin No. 2084, Flexible Fixture Hangers, which is being distributed with a broadside illustrating types of such hangers.





Hospital, University of Michigan, Ann Arbor, Mich., equipped with Kohler Automatic Electric Plant for emergency lighting. Inset: Kohler Automatic, Model D; 1500 watts, 110-volt D. C.

## The emergency lighting plant for hospitals

Every ship that sails the sea has an *emergency* electric plant, for lights and radio power when the big engines are disabled. Now hospitals are adopting the same protection for their operating rooms—setting up a life-saving defense against the ever-present hazard of failure of the regular current supply.

Many ships have adopted the Kohler Automatic Electric Plant. And, because this plant has proved its dependability in such trying service, and also because it is peculiarly adapted to emergency use, hospitals today are likewise installing the Kohler Automatic.

This plant is an independent electric generating unit. Eliminating the usual storage batteries, it has only an automobile-type starting battery, for automatic operation. It generates 110-volt current, requires no special wiring, and permits the use of standard lamps.

But these are details. The important fact is that with the Kohler Automatic you *know* that you are going to have brilliant, unflickering electric light to operate by—beyond the power of storms, fires, and floods to prevent.

Let us tell you more fully just how this is accomplished.

**KOHLER CO., Founded 1873, KOHLER, WIS.**

*Shipping Point, Sheboygan, Wis. · Branches in Principal Cities*

# KOHLER OF KOHLER

*Automatic Electric Plants—110 Volt D.C.*

*No Storage Batteries*

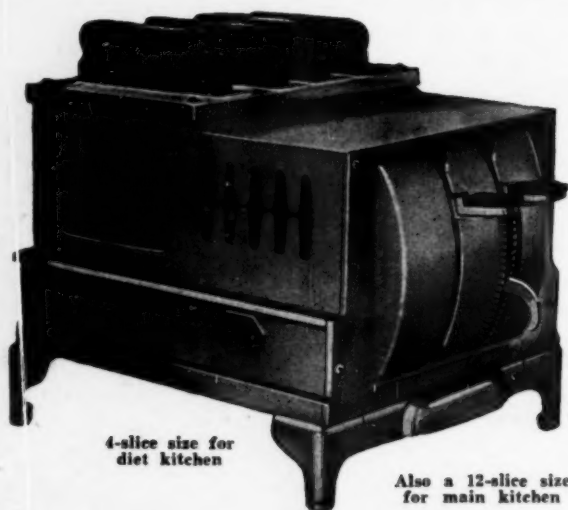
For complete index of advertisements refer to the Classified Directory

### KOHLER Plumbing Fixtures

*Kohler Co. also makes the celebrated Kohler Plumbing Fixtures. Ask your architects to specify this fine ware if you wish the best—at no higher cost.*

# TOASTMASTER

## Automatic Electric Toaster



## The Better Way to Make Toast —for 3 Reasons:

### 1. Better Toast—

crisp, tender, golden brown, delicious! Good toast is paramount in a hospital menu. It brightens the patient's day. The Toastmaster makes good toast—always!

### 2. Perfect Service—

While the nurse is serving one patient the Toastmaster is making toast for the next one. No waiting—no time wasted. Current shuts off automatically when toast is done. Oven heat keeps toast hot until served.

### 3. Economy—

Saving in help, fuel and bread. Hundreds of well known hospital users.

Write nearest office for full details.

## Waters-Genter Co.

209 N. 2nd St. Minneapolis, Minn.

Chicago Office: Waters-Genter Co.,  
123 W. Madison St., Chicago

Pacific Coast Sales Office:

C. N. HULDEBRANDT  
14 Montgomery St.  
San Francisco

Eastern Sales Office:

HECTOR C. ADAM, Inc.  
156 E. 42nd St.  
New York City

**The Witt Cornice Co.**—The Witt Cornice Co., Cincinnati, Ohio, manufacturers of corrugated cans and pails, have recently issued a new catalogue of twenty pages dealing with their product. Specifications and illustrations of the several types are also included.

**Hypodermic Needles and Syringes.**—A pamphlet of great practical value to all practicing physicians, "Standardizing on Sizes and Makes of Hypodermic Syringes and Needles," has been published by Becton, Dickinson and Co., Rutherford, N. J. It contains many suggestions as to the gauge and length of needles and the size of syringes which are generally used for the various operations. There are also notes regarding the care and sterilization of needles and syringes while the comparative merits and cost of steel, nickeloid, gold and platinum-iridium needles are outlined. The data was secured through consultation with many of the foremost surgeons in the country.

**Magnetstone in Construction.**—The American Magnetstone Corporation, Springfield, Ill., has recently distributed several folders containing information and specifications for installing magnetstone, such as composite flooring, stucco and Roman finishes, in buildings under construction.

**Water Heating by Gas.**—A hand book on water heating by gas has recently been published by the Bryant Heater and Manufacturing Co., 952 East Seventy-second street, Cleveland, Ohio. Many valuable diagrams and charts will be found that will be appreciated by the hospital engineer and the booklet acts as a suggestion in power house calculations. Specifications and dimensions for all kinds of buildings as well as hospitals are also in the booklet.

**Sanymetal Products.**—The Sanymetal Products Co., Cleveland, Ohio, has recently prepared a forty-page catalogue for distribution to architects, contractors, consultants and others planning to erect and equip modern buildings. The pages are replete with illustrations of installations of the Sanymetal products in hospital, hotel and commercial structures and the general design, construction, erection, finish and specifications are treated at length. Toilet partitions, toilet hardware and parts, hinges, wainscots and office partitions of varying types and construction are extensively described. A handy index to all material in the catalogue is printed on the last page.

**Patterson Kelley Purchases Otis Heater.**—The Patterson-Kelley Co., New York, recently purchased the patterns and patents of the Otis Heater from the King Construction Co., North Tonawanda, N. Y. The latter company quite recently bought out the Stewart Heater Co., Buffalo, a firm which has been a competitor of Patterson-Kelley for forty years. The new owners advise that they are in a position to manufacture all types of Otis Heaters and to supply repair parts for all old Otis Heaters.

**Soap Building.**—The Cowles Detergent Co., Cleveland, Ohio, have recently issued "Soap Building," one of the series of booklets discussing the principles and practices of modern cleaning and scientific washing. The series is designed to aid launderers in "Getting at the Science of the Wash."

**Interstate Shade Cloth Co.**—The Interstate Shade Cloth Co., Hoboken, N. J., manufacturers of shade cloths for every use, have recently issued three sample catalogues showing the various shades of cloth manufactured. Paragon, Sunlite and No-Lite shades are described and pictured in the three catalogues.

**Cantine's Coated Papers.**—The Martin Cantine Company, Saugerties, N. Y., are distributing a folder, "Canfold," which shows the possibilities of Cantine's Coated Papers for advertising brochure use.